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, 2020**

OR

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

Commission File Number 1-7293

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

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

14201 Dallas Parkway
Dallas, TX 75254
(Address of principal executive offices, including zip code)

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

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

Title of each class	Trading symbol	Name of each exchange on which registered
Common stock, $0.05 par value	THC	New York Stock Exchange
6.875% Senior Notes due 2031	THC31	New York Stock Exchange

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

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 every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes ☒ No ☐

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

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐
Smaller reporting company ☐ Emerging growth company ☐

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

Indicate by check mark whether the Registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

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, 2020, 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 $1.1 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 31, 2021, there were 106,196,295 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2021 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

TABLE OF CONTENTS

PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," the "Company," "we" or "us") is a diversified healthcare services company headquartered in Dallas, Texas. Through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI"), at December 31, 2020, we operated an expansive care network that included 65 hospitals and over 550 other healthcare facilities, including ambulatory surgery centers ("ASCs"), urgent care centers ("UCCs") , imaging centers, surgical hospitals, off-campus emergency departments and micro-hospitals. In addition, we operate Conifer Health Solutions, LLC through our Conifer Holdings, Inc. ("Conifer") subsidiary, which provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients. Following exploration of strategic alternatives for Conifer, in July 2019, we announced our intention to pursue a tax-free spin-off of Conifer as a separate, independent, publicly traded company. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other ("Hospital Operations"), Ambulatory Care and Conifer. Additional information about our business segments is provided below; statistical data for the segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report ("MD&A").

In 2020, the COVID-19 pandemic impacted all three segments of our business, as well as our patients, communities and employees. Throughout MD&A, we have provided additional information on the impact of the COVID-19 pandemic on our results of operations, set forth the steps we have taken, and are continuing to take, in response and described the legislative actions that have mitigated some of the economic disruption caused by the pandemic on our business. For information about risks and uncertainties around COVID-19 that could affect our results of operations, financial condition and cash flows, we refer you to the Risk Factors section below.

OPERATIONS

HOSPITAL OPERATIONS SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—At December 31, 2020, our subsidiaries operated 65 hospitals, serving primarily urban and suburban communities in nine states. Our subsidiaries had sole ownership of 57 of these hospitals, six were owned or leased by entities that are, in turn, majority owned by a Tenet subsidiary, and two were owned by third parties and leased by our wholly owned subsidiaries. Our Hospital Operations segment also included 157 outpatient centers at December 31, 2020, the majority of which are freestanding UCCs, provider-based diagnostic imaging centers, off-campus emergency departments, provider-based ASCs and micro-hospitals. In addition, at December 31, 2020, our subsidiaries owned or leased and operated: a number of medical office buildings, all of which were located on, or nearby, our hospital campuses; over 720 physician practices; three accountable care organizations and eight clinically integrated networks; and other ancillary healthcare businesses.

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; cardiovascular, digestive disease, neurosciences, musculoskeletal and obstetrics services; and outpatient services, including physical therapy. Many of our hospitals provide tertiary care services, such as cardiothoracic surgery, complex spinal surgery, neonatal intensive care and neurosurgery, and some also offer quaternary care in areas such as heart and kidney transplants. Moreover, a number of our hospitals offer advanced treatment options for patients, including limb-salvaging vascular procedures, acute level 1 trauma services, comprehensive intravascular stroke care, minimally invasive cardiac valve replacement, cutting-edge imaging technology, and telemedicine access for selected medical specialties.

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

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, 2020:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Baptist Medical Center(1)	Homewood	595	JV/Owned
Citizens Baptist Medical Center(1)(2)	Talladega	122	JV/Leased
Princeton Baptist Medical Center(1)(2)	Birmingham	505	JV/Leased
Shelby Baptist Medical Center(1)(2)	Alabaster	252	JV/Leased
Walker Baptist Medical Center(1)(2)	Jasper	267	JV/Leased
Arizona			
Abrazo Arizona Heart Hospital(3)	Phoenix	59	Owned
Abrazo Arrowhead Campus	Glendale	217	Owned
Abrazo Central Campus	Phoenix	206	Owned
Abrazo Scottsdale Campus	Phoenix	120	Owned
Abrazo West Campus	Goodyear	200	Owned
Holy Cross Hospital(4)(5)	Nogales	25	Owned
St. Joseph's Hospital(4)	Tucson	486	Owned
St. Mary's Hospital(4)	Tucson	400	Owned
California			
Desert Regional Medical Center(6)	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital and Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center(7)	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	172	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center(8)	San Ramon	123	JV/Owned
Sierra Vista Regional Medical Center	San Luis Obispo	162	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	536	Owned
Florida Medical Center – a campus of North Shore	Lauderdale Lakes	459	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	366	Owned
North Shore Medical Center	Miami	337	Owned
Palm Beach Gardens Medical Center	Palm Beach Gardens	199	Owned
Palmetto General Hospital	Hialeah	368	Owned
St. Mary's Medical Center	West Palm Beach	460	Owned
West Boca Medical Center	Boca Raton	195	Owned

Hospital	Location	Licensed Beds	Status
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	147	Owned
MetroWest Medical Center – Leonard Morse Campus(3)	Natick	86	Owned
Saint Vincent Hospital	Worcester	290	Owned
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	273	Owned
Harper University Hospital	Detroit	470	Owned
Huron Valley-Sinai Hospital	Commerce Township	158	Owned
Hutzel Women's Hospital	Detroit	114	Owned
Rehabilitation Institute of Michigan(3)	Detroit	69	Owned
Sinai-Grace Hospital	Detroit	404	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	109	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	479	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
The Hospitals of Providence East Campus	El Paso	182	Owned
The Hospitals of Providence Memorial Campus	El Paso	480	Owned
The Hospitals of Providence Sierra Campus	El Paso	306	Owned
The Hospitals of Providence Transmountain Campus	El Paso	108	Owned
Mission Trail Baptist Hospital	San Antonio	102	Owned
Nacogdoches Medical Center	Nacogdoches	161	Owned
North Central Baptist Hospital	San Antonio	443	Owned
Northeast Baptist Hospital	San Antonio	371	Owned
Resolute Health Hospital	New Braunfels	128	Owned
St. Luke's Baptist Hospital	San Antonio	287	Owned
Valley Baptist Medical Center	Harlingen	586	Owned
Valley Baptist Medical Center – Brownsville	Brownsville	240	Owned
Total Licensed Beds		**17,178**	

(1) Operated by a limited liability company formed as part of a joint venture with Baptist Health System, Inc. ("BHS"), a not-for-profit health system in Alabama; a Tenet subsidiary owned a 70% interest in the entity at December 31, 2020, and BHS owned a 30% interest.

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

(3) Specialty hospital.

(4) Owned by a limited liability company that, effective July 13, 2020 and at December 31, 2020, is wholly owned; through July 12, 2020, the entity was part of a joint venture with Dignity Health (which, following a 2019 merger with Catholic Health Initiatives, is now a part of CommonSpirit Health) and Ascension Arizona, each of which is a not-for-profit health system.

(5) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital.
(6) Lease expires in May 2027.
(7) Lease expires in July 2045.
(8) Owned by a limited liability company formed as part of a joint venture with John Muir Health ("JMH"), a not-for-profit health system in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the entity at December 31, 2020, and JMH owned a 49% interest.

Information regarding the utilization of licensed beds and other operating statistics at December 31, 2020 and 2019 can be found in MD&A.

At December 31, 2020, our Hospital Operations segment also included 48 diagnostic imaging centers, 15 off-campus emergency departments and 11 ASCs operated as departments of our hospitals and under the same license, as well as 83 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of six diagnostic imaging centers, 14 emergency facilities (13 of which are licensed as micro-hospitals), two ASCs and 61 UCCs. At December 31, 2020, USPI managed and operated nearly all of our Hospital Operations segment's 61 freestanding UCCs under our national MedPost brand. In December 2020, we entered into a definitive agreement to sell the majority of these UCCs (along with UCCs that are part of our Ambulatory Care segment) to an unaffiliated independent urgent care provider; we expect the transaction to be completed in the three months ending March 31, 2021, subject to regulatory approvals and customary closing conditions.

Over half of the outpatient centers in our Hospital Operations segment at December 31, 2020 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 (including COVID-19 surges) occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

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

Health Plans—We previously announced our intention to sell or otherwise dispose of our health plan businesses because they are not a core part of our long-term growth strategy. To that end, we sold, divested the membership of or discontinued four health plans in 2017, and we divested our Chicago-based preferred provider network and our Southern California Medicare Advantage plan in 2018. In addition, we surrendered the Certificate of Authority for our Arizona Medicare Advantage Plan and Medicaid Plan in 2020 to effectuate the withdrawal of our insurance business in Arizona. We have one additional health plan that is still being wound-down; during this time, it continues to be subject to numerous federal and state statutes and regulations related to its business operations, and it continues to be licensed by one or more agencies in the state in which it conducted business. In addition, insurance regulations in that state require us to maintain cash reserves in connection with the plan throughout the wind-down process.

AMBULATORY CARE SEGMENT

Our Ambulatory Care segment is comprised of the operations of USPI, which, at December 31, 2020, had interests in 308 ASCs, 40 UCCs (all of which are operated under the CareSpot brand), 24 imaging centers and 24 surgical hospitals in 31 states. We acquired 45 of these ASCs in December 2020 as part of a transaction announced on December 10, 2020, and we have entered into a definitive agreement to sell the UCCs (along with the majority of UCCs that are part of our Hospital Operations segment) in the near term, subject to regulatory approvals and customary closing conditions. These transactions will enable us to sharpen our focus on the continued growth and expansion of ambulatory surgical services. At December 31, 2020, we owned approximately 95% of USPI, and Baylor University Medical Center ("Baylor") owned approximately 5%.

Operations of USPI—USPI acquires and develops its facilities primarily through the formation of joint ventures with physicians and health systems. USPI's subsidiaries hold ownership interests in the facilities directly or indirectly and operate the facilities on a day-to-day basis through management services contracts.

USPI's surgical facilities specialize in both outpatient and inpatient cases. We believe surgery centers and surgical hospitals offer many advantages to patients and physicians, including increased affordability, predictability and convenience. USPI's facilities generally provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases than they could expect in an acute care hospital setting. In addition, many physicians choose to perform surgery in outpatient facilities because their patients prefer the comfort of a less institutional atmosphere and the expediency of simplified registration and discharge procedures. Moreover, USPI's facilities also serve as an alternative point-of-service as acute care hospitals manage their capacity during the COVID-19 pandemic and otherwise.

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

In addition to these technological and other clinical advancements, a changing payer environment has contributed to the growth of outpatient surgery relative to all surgery performed. Government programs, private insurance companies, managed care organizations and self-insured employers have implemented cost-containment measures to limit increases in healthcare expenditures, including procedure reimbursement. Furthermore, as self-funded employers are looking to curb annual increases in their employee health benefits costs, they continue to shift additional financial responsibility to patients through higher co-pays, deductibles and premium contributions. These cost-containment measures have contributed to the shift in the delivery of certain healthcare services away from traditional acute care hospitals to more cost-effective alternate sites, including surgery centers and surgical hospitals. We believe that surgeries performed at surgery centers and surgical hospitals are generally less expensive than acute care 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. In general, we believe that our focus on quality of care has a positive impact on, among other things, physician and patient satisfaction, as well as our revenues as governmental and private payers continue to move to pay-for-performance models.

We operate USPI's facilities, structure our joint ventures, and adopt staffing, scheduling, and clinical systems and protocols with the goal of increasing physician productivity. We believe that this focus on physician satisfaction, combined with providing high-quality healthcare in a friendly and convenient environment for patients, will continue to increase the number of procedures performed at our facilities each year. Our joint ventures also enable health 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 health systems to focus their attention and resources on their core business without the challenge of acquiring, developing and operating these facilities.

CONIFER SEGMENT

Nearly all of the services comprising the operations of our Conifer segment are provided by Conifer Health Solutions, LLC or one of its direct or indirect wholly owned subsidiaries. At December 31, 2020, we owned 76.2% of Conifer Health Solutions, LLC, and Catholic Health Initiatives ("CHI") had a 23.8% ownership position. (As a result of its 2019 merger with Dignity Health, CHI is now a part of CommonSpirit Health.) Following exploration of strategic alternatives for Conifer, in July 2019, we announced our intention to pursue a tax-free spin-off of Conifer as a separate, independent, publicly traded company. Completion of the proposed spin-off is subject to a number of conditions, including, among others, assurance that the separation will be tax-free for U.S. federal income tax purposes, execution of a restructured long-term services agreement between Conifer and Tenet, finalization of Conifer's capital structure, the effectiveness of appropriate filings with the U.S. Securities and Exchange Commission ("SEC"), and final approval from our board of directors. Although we are continuing to work on the Conifer spin-off, there can be no assurance regarding the timeframe for completing it, the allocation of assets and liabilities between Tenet and Conifer, that the other conditions of the spin-off will be met, or that it will be completed at all.

Services—Conifer provides comprehensive end-to-end and focused-point business process services, including hospital and physician revenue cycle management, patient communications and engagement support, and value-based care solutions, to hospitals, health systems, physician practices, employers and other clients.

Conifer's revenue cycle management solutions consist of: (1) patient services, including: centralized insurance and benefit verification; financial clearance, pre-certification, registration and check-in services; and financial counseling services, including reviews of eligibility for government healthcare or financial assistance programs, for both insured and uninsured patients, as well as qualified health plan coverage; (2) clinical revenue integrity solutions, including: clinical admission reviews; coding; clinical documentation improvement; coding compliance audits; charge description master management; and health information services; and (3) accounts receivable management solutions, including: third-party billing and collections; denials management; and patient collections. All of these solutions include ongoing measurement and monitoring of key revenue cycle metrics, as well as productivity and quality improvement programs. These revenue cycle management solutions assist hospitals, physician practices and other healthcare organizations in improving cash flow, revenue, and physician and patient satisfaction.

In addition, Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referral requests, calls regarding maternity services and other patient inquiries, (2) community education and outreach, and (3) scheduling and appointment reminders. Additionally, Conifer coordinates and implements marketing outreach programs to keep patients informed of screenings, seminars, and other events and services.

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

Clients—At December 31, 2020, Conifer provided one or more of the business process services described above to approximately 630 Tenet and non-Tenet hospital and other clients nationwide. Tenet and CHI facilities represented over 47% of these clients, and the remainder were unaffiliated health systems, hospitals, physician practices, self-insured organizations, health plans and other entities. Contractual agreements have been in place for many years documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations segment provides to Conifer. While Conifer prepares for the spin-off, these contracts have been renewed on a short-term basis with certain scope of services modifications; however, execution of restructured long-term services agreements between Conifer and Tenet is a condition to completion of the proposed spin-off. Conifer's agreement with CHI to provide patient access, revenue integrity, accounts receivable management and patient financial services to CHI's facilities expires in 2032. For the year ended December 31, 2020, approximately 40% of Conifer's net operating revenues were attributable to its relationship with Tenet and 43% were attributable to its relationship with CHI. As we pursue a tax-free spin-off of Conifer, we are continuing to market Conifer's revenue cycle management, patient communications and engagement services, and value-based care solutions businesses. The timing and uncertainty associated with our plans for Conifer may have an adverse impact on our ability to secure new clients for Conifer. Additional information about our Conifer operating segment can be found in MD&A.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2020 are set forth in the table beginning on page 2. We lease the majority of our outpatient facilities in both our Hospital Operations 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, where we consolidated several office locations in 2020. In addition, we maintain administrative offices in markets where we operate hospitals and other businesses, as well as our Global Business Center in the Philippines. 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.

HUMAN CAPITAL RESOURCES

Physicians—Our operations depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and other facilities, as well as physicians who affiliate with us and use our facilities as an extension of their practices. Under state laws and other licensing standards, medical staffs are generally self-governing organizations subject to ultimate oversight by the facility's local governing board. Members of the medical staffs of our facilities also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our facilities or admit their patients to competing facilities at any time. At December 31, 2020, we owned over 720 physician practices, and we employed (where permitted by state law) or otherwise affiliated with over 1,600 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals and outpatient centers. It is essential to our ongoing business and clinical program development 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—We believe each employee across our network has a role integral to our mission, which is to provide quality, compassionate care in the communities we serve. At December 31, 2020, we employed approximately 110,000 people (of which approximately 22% were part-time employees) in our three business segments, as follows:

Hospital Operations	77,960
Ambulatory Care	21,125
Conifer	10,915
Total	**110,000**

At December 31, 2020, our employee headcount had decreased by approximately 3,600 employees as compared to December 31, 2019, primarily due to workforce reductions and voluntary separations of employees in our Hospital Operations segment offset by an increased number of USPI employees due to acquisitions of facilities in our Ambulatory Care segment. At December 31, 2020, we had employees in every state in the United States, as well as approximately 1,700 employees providing support across our entire network at our Global Business Center in the Philippines. Approximately 35% of our employees are nurses.

We have established – and continue to enhance and refine – a comprehensive set of practices for recruiting, managing and optimizing the human resources of our organization. In many cases, we utilize objective benchmarking and other tools in our efforts, including a commercial product that is widely used in the healthcare industry and provides metrics in such areas as organizational effectiveness, voluntary turnover and staffing efficiencies. In general, we seek to attract, develop and retain an engaged workforce, cultivate a high-performance culture that embraces data-driven decision-making, and improve talent management processes to promote diversity and inclusion. To that end, we offer: (i) a competitive range of compensation and benefit programs designed to reward performance and promote wellbeing; (ii) opportunities for continuing education and advancement through a broad range of clinical and leadership training experiences; (iii) a supportive, inclusive and patient-centered culture based on respect for others; (iv) company-sponsored efforts encouraging and recognizing volunteerism and community service; (v) a code of conduct that promotes integrity, accountability and transparency, among other high ethical standards; and (vi) a focus on employee welfare, including the implementation of additional safety measures in response to the COVID-19 pandemic. We also continue to focus on the hiring, advancement and retention of underrepresented populations to further our objective of fostering an engaging culture with a workforce and leadership teams that represent the markets we serve. As of December 31, 2020, our total workforce was approximately 75% female, and approximately 47% of our employees self-identified as racially or ethnically diverse. Approximately 53% of new employees (i.e., those we hired in 2020) self-identified as racially or ethnically diverse. Our newly established Diversity Council, which consists of leaders representing different facets of our enterprise, is working together to provide tools, guidelines and training with respect to best practices in this area.

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, which shortage has been exacerbated by the COVID-19 pandemic. Moreover, we hire many newly licensed nurses in addition to experienced nurses, which requires us to invest in their training.

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

Union Activity and Labor Relations—At December 31, 2020, approximately 28% of the employees in our Hospital Operations segment were represented by labor unions. Less than 1% of the total employees in both our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 35 of our hospitals, the majority of which are in California, Florida and Michigan. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is a possibility that strikes could occur, and our continued operation during any strikes could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods, which could result in increases in salaries, wages and benefits expense.

COMPETITION

HEALTHCARE SERVICES

We believe our hospitals and outpatient facilities compete within local communities on the basis of many factors, including: quality of care; location and ease of access; the scope and breadth of services offered; reputation; and the caliber of the facilities, equipment and employees. In addition, the competitive positions of hospitals and outpatient facilities depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of those facilities, as well as physicians who affiliate with and use outpatient centers as an extension of their practices. Physicians often serve on the medical staffs of more than one facility, and they are typically free to terminate their association with such facilities or admit their patients to competing facilities at any time.

Another major factor in the competitive position of a hospital or outpatient facility is the ability to negotiate contracts with managed care plans. Health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), third-party administrators, and other third-party payers use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals’ established charges. These negotiated discounts generally limit a hospital or other facility’s ability to increase reimbursement rates to offset increasing costs. Trends toward clinical and pricing transparency may also impact a healthcare facility’s competitive position in ways that are difficult to predict.

In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments and diagnostic imaging centers in the geographic areas in which we operate has increased significantly. Some of these facilities are physician-owned. Moreover, we expect to encounter additional 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 in the future. Some of the hospitals that compete with our hospitals are owned by tax-supported government agencies, and many others are owned by not-for-profit organizations that may have financial advantages not available to our facilities, including (i) support through endowments, charitable contributions and tax revenues, (ii) access to tax-exempt financing, and (iii) 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 most of our hospitals. State laws that require findings of need for construction and expansion of healthcare facilities or services (as described in “Healthcare Regulation and Licensing – Certificate of Need Requirements” below) may also impact competition.

Our strategies are designed to help our hospitals and outpatient facilities remain competitive, to attract and retain an appropriate number of physicians of distinction in various specialties, as well as skilled clinical personnel and other healthcare professionals, and to increase patient volumes. To that end, we have made significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. 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. Moreover, we participate in various value-based programs to improve quality and cost of care. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in more appropriate lengths of stay, as well as reductions in readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effects of: (1) reducing costs; (2) increasing payments from Medicare and certain managed care payers for our services as governmental and private payers continue to move to pay-for-performance models, and the commercial market continues to move 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. It should be noted, however, that we do face competition from other health systems that are implementing similar strategies.

We also recognize that 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. Generally, we compete for these contracts on the basis of price, market reputation, geographic location, quality and range of services, caliber of the medical staff and convenience. 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. Price transparency initiatives and increasing vertical integration efforts involving third-party payers and healthcare providers, among other factors, may increase these challenges. Furthermore, the ongoing trend toward consolidation among non-government payers tends to increase their bargaining power over contract terms.

To bolster our competitive position, we have 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 also continue to engage in contracting strategies that create shared value with payers.

In addition, we have significantly increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, increased predictability and efficiency for physicians, and (for most services) lower costs for payers than would be incurred with a hospital visit. We believe that emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our ambulatory care business, cultivation of our culture of service and participation in Medicare Advantage health plans that have been experiencing higher growth rates than traditional Medicare, among other strategies, will also help us address competitive challenges in our markets.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Conifer faces competition from existing participants and new entrants to the revenue cycle management market, some of which may have significantly greater capital resources than Conifer. In addition, the internal revenue cycle management staff of hospitals and other healthcare providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions may choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, including: software vendors and other technology-supported revenue cycle management business process outsourcing companies; traditional consultants, either specialized healthcare consulting firms or healthcare divisions of large accounting firms; and large, non-healthcare focused business process and information technology outsourcing firms.

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

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

HEALTHCARE REGULATION AND LICENSING

HEALTHCARE REFORM

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") extended health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. To fund the expansion of insurance coverage, the ACA includes measures designed to promote quality and cost efficiency in healthcare delivery and to generate budgetary savings in the Medicare and Medicaid programs. In addition, the ACA contains provisions intended to strengthen fraud and abuse enforcement.

The initial expansion of health insurance coverage under the ACA resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as a 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 recent years, the healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to significantly modify or repeal and potentially replace the ACA. Effective January 2019, Congress eliminated the financial penalty for noncompliance under the ACA's individual mandate provision, which requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards. On November 10, 2020, the U.S. Supreme Court heard oral arguments in the matter of *California v. Texas* addressing whether the individual mandate itself is unconstitutional now that Congress has eliminated the tax penalty that was intended to enforce it. Conversely, members of Congress and other politicians have proposed measures that would expand government-sponsored coverage, including single-payer plans, such as Medicare for All. We cannot predict whether the U.S. Supreme Court's decision will invalidate the Affordable Care Act, nor can we predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

Furthermore, we are unable to predict the impact on our future revenues and operations of (1) the final decision in *California v. Texas* and other court challenges to the ACA, (2) administrative, regulatory and legislative changes, including expansion of government-sponsored coverage, or (3) market reactions to those changes. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased patient volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows.

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") proscribe 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. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program. Moreover, the Affordable Care Act amended the Anti-kickback Statute to provide that intent to violate the Anti-kickback Statute is not required; rather, intent to violate the law generally is all that is required.

Sanctions for violating the Anti-kickback Statute include criminal and civil penalties, as well as fines and mandatory exclusion from government programs, such as Medicare and Medicaid. In addition, submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act ("FCA"). Furthermore, it is a violation of the federal Civil Monetary Penalties Law ("CMPL") 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 – referred to as the "Safe Harbor" regulations – that describe some of the conduct and business relationships that are permissible under the Anti-kickback Statute. Historically, Safe Harbors for various activities have included 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; ASCs; referral agreements for specialty services; cost-sharing waivers for pharmacies and emergency ambulance services; and local transportation. In December 2020, the HHS Office of Inspector General ("OIG") published new rules (the "2020 AKS and CMPL Update") that updated the Safe Harbor regulations and the CMPL. The 2020 AKS and CMPL Update modified existing Safe Harbors and added new Safe Harbors, as well as a new CMPL exception to remove barriers to more effective coordination and management of patient care and delivery of value-based care. The 2020 AKS and CMPL Update includes: three new Safe Harbors to protect certain payments among individuals and entities in a value-based arrangement; a Safe Harbor to protect certain remuneration provided in connection with CMS-sponsored models; a Safe Harbor to protect donations of cybersecurity technology; and a Safe Harbor to protect the furnishing of certain tools and support to patients in order to improve quality, health outcomes and efficiency. 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 physician referrals 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 ASC if those services are included in the ASC's composite Medicare payment rate. However, if the ASC is separately billing Medicare for designated health services that are not covered under its composite Medicare payment rate, or if either the ASC or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ASC 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 ordinary relationships between physicians and providers of designated health services, such as hospitals. In December 2020, CMS published new rules (the "2020 Stark Law Update") that include new exceptions for: certain value-based compensation arrangements between or among physicians, providers and suppliers; limited remuneration to a physician for the provision of items and services without the need for a signed writing and compensation that is set in advance if certain conditions are met; and the protection of arrangements involving the donation of certain cybersecurity technology and related services, including certain cybersecurity hardware donations. The 2020 Stark Law Update also includes several new rules and clarifications to existing Stark Law regulations and key definitions intended to clarify some of the more challenging aspects of Stark Law compliance. CMS explained that the purpose of the 2020 Stark Law Update is to modernize and clarify the regulations to support the innovation necessary for a healthcare delivery and payment system that pays for value and to reduce unnecessary regulatory burdens on physicians and other healthcare providers and suppliers, while reinforcing the physician self-referral law's goal of protecting against program and patient abuse.

A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

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

Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. Physician-owned hospitals are also currently subject to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements.

Implications of Fraud and Abuse Laws—At December 31, 2020, the majority of the facilities that operate as surgical hospitals in our Ambulatory Care segment are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals. Furthermore, the majority of ASCs in our Ambulatory Care segment, which are owned by joint ventures with physicians or health 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, although this risk has been reduced as a result of the 2020 AKS and CMPL Update and the 2020 Stark Law Update, which updates are intended to remove potential federal regulatory barriers to care coordination and value-based care.

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 ASCs could be eliminated. We are continuing to enter into new financial arrangements with physicians and other providers in a manner we believe complies with applicable anti-kickback and anti-fraud and abuse laws. However, governmental officials responsible for enforcing these laws may nevertheless assert that we are in violation of these provisions. In addition, these statutes or regulations may be interpreted and enforced by the courts in a manner that is not consistent with our interpretation. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that USPI or its subsidiaries has violated any of these laws could give certain of our joint venture partners a right to terminate their relationships with us; and any similar determination with respect to Conifer or any of its subsidiaries could give Conifer's clients the right to terminate their services agreements with us. Moreover, any violations by and resulting penalties or exclusions imposed upon USPI's joint venture partners or Conifer's clients could adversely affect their financial condition and, in turn, have a material adverse effect on our business and results of operations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

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

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

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

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

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

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

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

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

HEALTHCARE FACILITY LICENSING REQUIREMENTS

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

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

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

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

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates or determinations of need, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Our subsidiaries operate acute care hospitals in five states that require a form of state approval under certificate of need programs applicable to those hospitals. Approximately 30% of our licensed hospital beds are located in these states (namely, Alabama, Massachusetts, Michigan, South Carolina and Tennessee). The certificate of need programs in most of these states, along with several others, also apply to ASCs.

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, 2020.

ANTITRUST LAWS

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

Antitrust enforcement in the healthcare industry is currently a priority of the U.S. Federal Trade Commission ("FTC"). In recent years, the FTC has filed multiple administrative complaints and public comments challenging hospital transactions in several states. The FTC has focused its enforcement efforts on preventing hospital mergers that may, in the government's view, leave insufficient local options for patient services. In the three months ended December 31, 2020, the FTC took action to challenge our planned sale of two Tennessee hospitals to an unaffiliated third party; as a result, we determined in December 2020 that we no longer intend to pursue the transaction. In addition to hospital merger enforcement, the FTC has given increased attention to the effect of combinations involving other healthcare providers, including physician practices. The FTC has also entered into numerous consent decrees in the past several years settling allegations of price-fixing among providers.

REGULATIONS AFFECTING CONIFER'S OPERATIONS

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

BILLING AND COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act ("FDCPA") regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by Conifer's third-party debt collection vendors are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. Conifer audits and monitors its vendors for compliance, but there can be no assurance that such audits and monitoring will detect all instances of potential non-compliance.

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

Conifer and its subsidiaries are also subject to both federal and state regulatory agencies who have the authority to investigate consumer complaints relating to a variety of consumer protection laws, including but not limited to the Telephone

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

COMPLIANCE AND ETHICS

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

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

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

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) assessing, critiquing, and (as appropriate) drafting and distributing company policies and procedures; (2) 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; (3) creating and disseminating the Company's *Code of Conduct* and obtaining certifications of adherence to the *Code of Conduct* as a condition of employment; (4) maintaining and promoting the Company's Ethics Action Line, a 24-hour, toll-free hotline that allows for confidential reporting of issues on an anonymous basis and emphasizes the Company's no-retaliation policy; and (5) 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.

Code of Conduct—All of our employees and officers, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Code of Conduct* to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and all of our contractors having functional roles similar to our employees are also required to abide by our *Code of Conduct*. The standards therein reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our *Code of Conduct* covers 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 and officer, as well as our board of directors and certain physicians and contractors. All such persons are required to report incidents that they believe in good faith may be in violation of the *Code of Conduct* or our policies, and all 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 any individual who makes a report has the option to remain anonymous. Incidents of alleged financial improprieties reported to the Ethics Action Line or the ethics and compliance department are communicated to the audit committee of our board of directors. Reported cases that involve a possible violation of the law or regulatory policies and procedures are referred to the ethics and compliance department for investigation, although certain matters may be referred out to the law or human resources department. Retaliation against anyone in connection with reporting ethical concerns is considered a serious violation of our *Code of Conduct*, and, if it occurs, it will result in discipline, up to and including termination of employment.

Non-Prosecution Agreement—In September 2016, the Company and certain of its subsidiaries, including Tenet HealthSystem Medical, Inc. ("THSMI"), Atlanta Medical Center, Inc. and North Fulton Medical Center, Inc., executed agreements with the U.S. Department of Justice ("DOJ") and others to resolve a civil qui tam action and criminal investigation. In accordance with the terms of the resolution agreements, THSMI entered into a Non-Prosecution Agreement (as amended, the "NPA") with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia, which expired on November 1, 2020. For additional information, we refer you to the copy of the NPA attached as an exhibit to our Current Report on Form 8-K filed with the SEC on October 3, 2016, and the letter agreement amending the term of the NPA attached as an exhibit to our Report on Form 10-Q for the quarter ended June 30, 2018.

Availability of Documents—The full text of our *Quality, Compliance and Ethics Program Charter,* our *Code of Conduct*, and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the "Our Commitment To Compliance" caption in the "About Us" section. A copy of our *Code 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 *Code of Conduct* and any grant of a waiver from a provision of the *Code of Conduct* requiring disclosure under applicable SEC rules will be disclosed at the same location as the *Code of Conduct* on our website.

INSURANCE

Property Insurance—We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy periods April 1, 2019 through March 31, 2020 and April 1, 2020 through March 31, 2021, we have coverage totaling $850 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million for floods, $200 million for earthquakes and a per-occurrence sub-limit of $200 million for named windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and named windstorms, the total $850 million limit of coverage per occurrence applies. For both policy periods, deductibles are 5% of insured values up to a maximum of $40 million for California earthquakes, $25 million for floods and named windstorms, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Floods and certain other covered losses, including fires and other perils, have a minimum deductible of $1 million.

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

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

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

COMPANY INFORMATION

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

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

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

FORWARD-LOOKING STATEMENTS

This report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, target, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements, including (but not limited to) disclosure regarding (i) the impact of the COVID-19 pandemic, (ii) our future earnings, financial position, and operational and strategic initiatives, and (iii) developments in the healthcare industry. Forward-looking statements represent management's expectations, based on currently available information, as to the outcome and timing of future events, but, by their nature, address matters that are indeterminate. They involve known and unknown risks, uncertainties and other factors, many of which we are unable to predict or control, that may cause our actual results, performance or achievements to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the following:

- The impact of the COVID-19 pandemic on our future operations, financial condition and liquidity, particularly if the U.S. economy remains unstable for a significant period of time;
- The impact on our business of any future modifications to or court decisions affecting the viability of the Affordable Care Act and the enactment of, or changes in, other statutes and regulations affecting the healthcare industry generally, as well as reductions to Medicare and Medicaid payment rates or changes in reimbursement practices or to Medicaid supplemental payment programs;
- Adverse regulatory developments, government investigations or litigation, as well as the timing and impact of additional changes in federal tax laws, regulations and policies, and the outcome of pending and any future tax audits, disputes and litigation associated with our tax positions;
- Our ability to enter into or renew managed care provider arrangements on acceptable terms; changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under managed care agreements; and the impact of the industry trend toward value-based purchasing and alternative payment models;
- The impact of competition on all aspects of our business; and our success in recruiting and retaining physicians and other healthcare professionals;
- Our ability to achieve operating and financial targets, attain expected levels of patient volumes, and identify and execute on measures designed to save or control costs or streamline operations, including our ability to realize savings under our cost-reduction initiatives;
- Potential security threats, catastrophic events and other disruptions affecting our information technology and related systems;
- Operational and other risks associated with acquisitions and joint venture arrangements;
- The outcome of the process we have undertaken to pursue a tax-free spin-off of Conifer as a separate, independent, publicly traded company, as well as potential disruptions to our business or diverted management attention as a result of the Conifer spin-off process;
- The impact of our significant indebtedness; the availability and terms of capital to refinance existing debt, fund our operations and expand our business; and our ability to comply with our debt covenants and, over time, reduce leverage;
- The effect that general adverse economic conditions, consumer behavior and other factors have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things; and increases in the amount of uninsured accounts and deductibles and copays for insured accounts; and
- Other factors and risks referenced in this report and our other public filings.

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

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

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 and make an investment in our securities risky. If one or more of the events discussed in this report were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment. Additional risks and uncertainties not presently known, or currently deemed immaterial, may also constrain our business and operations.

Risks Related to Our Overall Operations

The COVID-19 pandemic has significantly affected our operations and financial condition, and it continues to do so; moreover, our liquidity could be negatively impacted, particularly if the U.S. economy remains unstable for a significant period of time.

In 2020, the COVID-19 pandemic impacted all three segments of our business, as well as our patients, communities and employees. The spread of COVID-19 and the ensuing response of federal, state and local authorities beginning in March 2020 resulted in a material reduction in our patient volumes and also adversely affected our net operating revenues in the year ended December 31, 2020. Known and unknown risks and uncertainties caused by the ongoing COVID-19 pandemic, including those described below, have had, and are continuing to have, a material impact on our business, financial condition, results of operations and cash flows; such risks and uncertainties may heighten other risks to our business as described herein.

In accordance with governmental mandates, from mid-March through early May 2020, we suspended elective procedures at many of our hospitals and ASCs; we also voluntarily reduced operating hours or temporarily closed some of our outpatient centers during this time. Restrictive measures, including travel bans, social distancing, quarantines and shelter-in-place orders, also reduced the number of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits. Collectively, these measures had an adverse impact on our business and financial results in the year ended December 31, 2020, as further described in MD&A. Given the geographic diversity of our operations and the impact of COVID-19 surges, we have been and may in the future be forced to reduce services at individual locations again. In general, federal, state or local laws, regulations, orders or other actions imposing direct or indirect restrictions on our business due to the COVID-19 pandemic or otherwise may have an adverse impact on our financial condition, results of operations and cash flows.

We are treating patients with COVID-19 in our hospitals and, in some areas, the increased demand for care is putting a strain on our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. Increased demand could also cause some of our hospitals to reduce their operating capacity. In addition, even with appropriate protective measures, exposure to COVID-19 increases the risk that physicians, nurses and others in our hospitals may contract the virus, which could further limit our ability to treat all patients who seek care. If conditions worsen, some of our hospitals may experience workforce disruptions. Furthermore, we may be subject to lawsuits from patients, employees and others exposed to COVID-19 at our facilities. Such actions may involve large demands, as well as substantial defense costs. Our professional and general liability insurance may not cover all claims against us.

We have experienced supply chain disruptions, including shortages and delays, as well as significant price increases in medical supplies, particularly for personal protective equipment. COVID-19 surges in our markets and elsewhere could further impact the cost of medical supplies, and supply shortages and delays may impact our ability to see, admit and treat patients.

Broad economic factors resulting from the COVID-19 pandemic, including increased unemployment rates and reduced consumer spending have impacted, and are continuing to impact, our service mix, revenue mix and patient volumes. Business

closings and layoffs in the areas we operate may lead to increases in the uninsured and underinsured populations and adversely affect demand for our services, as well as the ability of patients to pay for services as rendered. Any increase in the amount of or deterioration in the collectability of patient accounts receivable could adversely affect our cash flows and results of operations. If general economic conditions continue to deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be impacted. There can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

Changes to COVID-19-related relief measures may have an adverse impact on our business, financial condition, results of operations or cash flows, and we cannot predict whether we will qualify, apply for, receive or benefit from additional financial assistance in the future or whether any future laws and regulations related to or in response to the COVID-19 pandemic will impact our operations.

As described in detail in MD&A, the Coronavirus Aid, Relief, and Economic Security Act and other legislative and regulatory actions have provided relief measures intended to mitigate some of the economic disruption caused by the COVID-19 pandemic on our business; however, interpretations of and regulations relating to these laws are subject to change in ways that may adversely affect our funding or eligibility to participate. For example, if we are unable to attest to or comply with the terms and conditions associated with the grants we have received from COVID-19-related stimulus legislation, our ability to retain some or all of the distributions received may be impacted. In general, we are unable to predict whether changes, if any, to existing or future COVID-19 relief measures will have an adverse impact on our business, financial condition, results of operations or cash flows. Moreover, some of the measures allowing for flexibility in delivery of care and financial support for healthcare providers are available only for the duration of the public health emergency as declared by the Secretary of HHS, and it is unclear whether or for how long the HHS declaration will be extended past its current expiration date.

The federal government and state and local governments may consider additional stimulus and relief efforts, but we are unable to predict whether any such measures will be enacted or their impact on our operations. There can also be no assurance that we will be eligible or apply for, or receive or benefit from, additional COVID-19-related stimulus assistance in the future, nor can there be any assurance as to the amount and type of assistance we may receive or seek or whether we will be able to comply with the applicable terms and conditions to retain such assistance.

At this time, we remain unable to fully assess the extent to which the amounts or benefits received under current or future relief measures related to or in response to the COVID-19 pandemic will offset the negative impacts on our operations arising from the COVID-19 pandemic.

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

The initial expansion of health insurance coverage under the Affordable Care Act resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as a 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 recent years, the healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to significantly modify or repeal and potentially replace the ACA. In November 2020, the U.S. Supreme Court heard oral arguments in the matter of *California v. Texas* addressing whether the ACA's individual mandate provision is unconstitutional given that Congress eliminated the tax penalty that was intended to enforce it in January 2019. Conversely, members of Congress and other politicians have proposed measures that would expand government-sponsored coverage, including single-payer plans, such as Medicare for All. We cannot predict whether the U.S. Supreme Court's decision will invalidate the Affordable Care Act, nor can we predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

We are also unable to predict the impact on our future revenues and operations of (1) the final decision in *California v. Texas* and other court challenges, (2) administrative, regulatory and legislative changes, including expansion of government-sponsored coverage, or (3) market reactions to those changes. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased patient volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows.

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, 2020, approximately 20% and 8% of our net patient service revenues less implicit price concessions for the hospitals and related outpatient facilities in our Hospital Operations segment were from the Medicare program and various state Medicaid programs, respectively, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows.

Even prior to the COVID-19 pandemic, several states in which we operate faced budgetary challenges that resulted 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 supplemental payment 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, including legislative and regulatory changes, could result in future reductions to Medicaid payments, payment delays, changes to Medicaid supplemental payment programs or additional taxes on hospitals.

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

Violations of existing regulations or failure to comply with new or changed regulations could harm our business and financial results.

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 legislation, regulation or enforcement efforts, particularly in light of the recent changes in Presidential and Congressional leadership. 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.

In addition, our operations at our Global Business Center in the Philippines are subject to certain U.S. healthcare industry-specific requirements, as well as U.S. and foreign laws applicable to businesses generally, including anti-corruption laws. One such law, the Foreign Corrupt Practices Act ("FCPA"), regulates U.S. companies in their dealings with foreign officials, prohibiting bribes and similar practices, and requires that they maintain records that fairly and accurately reflect transactions and appropriate internal accounting controls. FCPA enforcement actions continue to be a high priority for the SEC and the DOJ. Our failure to comply with the FCPA could result in the imposition of fines and other civil and criminal penalties, which could be significant.

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 claims and other legal actions in the ordinary course of business. In addition, from time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation (including employee class action lawsuits) concerning our application of various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. Some of these actions 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 a significant rise in the cost of such insurance due to increased litigation. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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

For the year ended December 31, 2020, approximately 66%, or $9.0 billion, of our net patient service revenues for the hospitals and related outpatient facilities in our Hospital Operations segment was attributable to managed care payers, including Medicare and Medicaid managed care programs. In 2020, our commercial managed care net inpatient revenue per admission from the hospitals in our Hospital Operations segment was approximately 95% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. Our ability to negotiate favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans, as well as add new facilities to our existing agreements at contracted rates, significantly affects our revenues and operating results. We currently have thousands of managed care contracts with various HMOs and PPOs; however, our top 10 managed care payers generated 62% of our managed care net patient service revenues for the year ended December 31, 2020. Because of this concentration, we may experience a short or long-term adverse effect on our net operating revenues if we cannot renew, replace or otherwise mitigate the impact of expired contracts with significant payers. Furthermore, any disputes between us and significant managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows. At December 31, 2020, 66% of our net accounts receivable for our Hospital Operations segment was due from managed care payers.

Private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. Price transparency initiatives and increasing vertical integration efforts involving third-party payers and healthcare providers, among other factors, may increase these challenges. Any negotiated discount programs we agree to generally limit our ability to increase reimbursement rates to offset increasing costs. Furthermore, the ongoing trend toward consolidation among non-government payers tends to increase their bargaining power over contract terms. Our future success depends, in part, on our ability to retain and renew our existing managed care contracts and enter into new managed care contracts on competitive terms. Generally, we compete for these contracts on the basis of price, market reputation, geographic location, quality and range of services, caliber of the medical staff and convenience. Other healthcare providers, including some with greater financial resources, greater geographic coverage or a wider range of services, 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. 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.

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

Value-based purchasing and alternative payment model initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities, and may negatively impact our revenues if we are unable to meet expected quality standards. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions ("HACs"), unless the conditions were present at admission. Hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year receive reduced Medicare reimbursements. Moreover, the Affordable Care Act 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 develop and 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. Congress has defined – both through the ACA and previous legislation – a number of specific demonstrations for CMS to conduct, including bundled payment models. Generally, the bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health care. Provider participation in some of these models is voluntary; however, participation in certain other bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. 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. We cannot predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

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

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 and other aspects of our operations.

We believe our hospitals and outpatient facilities compete for patients within local communities on the basis of many factors, including: quality of care; location and ease of access; the scope and breadth of services offered; reputation; and the caliber of the facilities, equipment and employees. In addition, the competitive positions of hospitals and outpatient facilities depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of those facilities, as well as physicians who affiliate with and use outpatient centers as an extension of their practices. Another major factor in the competitive position of a hospital or outpatient facility is the ability to negotiate contracts with managed care plans. HMOs, PPOs, third-party administrators and other third-party payers use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. 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. Furthermore, healthcare consumers are now able to access hospital performance data on quality measures and patient satisfaction, as well as standard charges for services, to compare competing providers; if any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or patient satisfaction surveys, or if our standard charges are or are perceived to be higher than our competitors, we may attract fewer patients. Additional quality measures and trends toward clinical or billing transparency may have an unanticipated impact on our competitive position and patient volumes.

Some of the hospitals that compete with our hospitals are owned by tax-supported government agencies, and many others are owned by not-for-profit organizations that may have financial advantages not available to our facilities, including (i) support through endowments, charitable contributions and tax revenues, (ii) access to tax-exempt financing, and (iii) 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 most of our hospitals. 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" above) may also impact competition. In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments and diagnostic imaging centers in the geographic areas in which we operate has increased significantly. Some of these facilities are physician-owned. Moreover, we expect to encounter additional 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 in the future.

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

We expect to encounter increased competition from health insurers and private equity companies seeking to acquire providers in the markets where we operate physician practices and, where permitted by law, employ physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Furthermore, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. All arrangements with physicians must also be fair market value and commercially reasonable. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may choose not to refer patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

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

The operations of our facilities depend 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, which shortage has been exacerbated by the COVID-19 pandemic. As a result, from time to time, we have been and we may continue to be required to enhance wages and benefits to recruit and retain experienced employees, make greater investments in education and training for newly licensed medical support personnel, or hire more expensive temporary or contract employees. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit volumes, which would have a corresponding adverse effect on our net operating revenues. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Increased labor union activity is another factor that can adversely affect our labor costs. At December 31, 2020, approximately 28% of the employees in our Hospital Operations segment were represented by labor unions. Less than 1% of the total employees in both our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 35 of our hospitals, the majority of which are in California, Florida and Michigan. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is a possibility that strikes could occur, and our continued operation during any strikes

could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods, which could result in increases in salaries, wages and benefits expense.

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

Information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive and confidential data, including protected health information, personally identifiable information, and our proprietary and confidential business performance data. We utilize electronic health records and other information technology in connection with all of our operations, including our billing, supply chain and labor management functions. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the integrity, security and availability of the data we process, transmit and store, the information technology and infrastructure we use have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. The COVID-19 pandemic has placed additional stress on our information technology systems, and the risk of disruption to these systems is elevated in the current environment. In particular, we face a heightened risk of cybersecurity threats, including ransomware attacks targeting healthcare providers.

In general, attacks or breaches could impact the integrity, security or availability of data we process, transmit or store, or they could disrupt our information technology systems, devices or businesses. While we are not aware of having experienced a material breach of our systems, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we will be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, and invest in new technology designed to mitigate security risks. Furthermore, we have an increased risk of security breaches or compromised intellectual property rights as a result of outsourcing certain functions unrelated to direct patient care. Though we have insurance against some cyber-risks and attacks, it may not offset the financial impact of a material loss event.

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

Our networks and technology systems have experienced disruption due to events such as system implementations, upgrades, and other maintenance and improvements, and they are subject to disruption in the future for similar events, as well as catastrophic events, including a major earthquake, fire, hurricane, telecommunications failure, ransomware attack, terrorist attack or the like. Any breach or system interruption of our information systems or of third parties with access to our sensitive and confidential data could result in: the unauthorized disclosure, misuse, loss or alteration of such data; interruptions and delays in our normal business operations (including the collection of revenues); patient harm; potential liability under privacy, security, consumer protection or other applicable laws; regulatory penalties; and negative publicity and damage to our reputation. Any of these could have a material adverse effect on our business, financial position, results of operations or cash flows.

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

Our future financial performance and level of profitability is dependent, in part, on various cost-reduction initiatives, including our efforts to outsource certain functions unrelated to direct patient care. We may encounter challenges in executing our cost-reduction initiatives and not achieve the intended cost savings. In addition, we may face wrongful termination, discrimination or other legal claims from employees affected by any workforce reductions, and we may incur substantial costs defending against such claims, regardless of their merits. Such claims may also significantly increase our severance costs. Workforce reductions, whether as a result of internal restructuring or in connection with outsourcing efforts, may result in the loss of numerous long-term employees, the loss of institutional knowledge and expertise, the reallocation of certain job responsibilities and the disruption of business continuity, all of which could negatively affect operational efficiencies and

increase our operating expenses in the short term. Moreover, outsourcing and offshoring expose us to additional risks, such as reduced control over operational quality and timing, foreign political and economic instability, compliance and regulatory challenges, and natural disasters not typically experienced in the United States, such as volcanic activity and tsunamis. Our failure to effectively execute our cost-reduction initiatives may lead to significant volatility, and a decline, in the price of our common stock. We cannot guarantee that our cost-reduction initiatives will be successful, and we may need to take additional steps in the future to achieve our profitability goals.

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

As a result of factors that have negatively affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. During the year ended December 31, 2020, we recorded impairment charges of $92 million. Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospitals' most recent projections. If these projections are not met, or negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material. Future restructuring of our operating structure that changes our goodwill reporting units could also result in future impairments of our goodwill. Any such charges could negatively impact our results of operations.

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, 2020, we had federal net operating loss ("NOL") carryforwards of approximately $2.4 billion pre-tax available to offset future taxable income. Of these NOL carryforwards, $1.13 billion will expire in the years 2021 to 2034, and $1.24 billion has no expiration date. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income that may be offset by the NOL carryforwards if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount of taxable income we generate in future periods. There is no assurance that we will be able to fully utilize the NOL carryforwards. Furthermore, we could be required to record a valuation allowance related to the amount of the NOL carryforwards that may not be realized, which could adversely impact our results of operations.

Risks Related to Acquisitions, Divestitures and Joint Ventures

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

We have completed a number of acquisitions in recent years, and we expect to pursue similar transactions in the future. A key business strategy for USPI, in particular, is the acquisition and development of facilities, primarily through the formation of joint ventures with physicians and health system partners. With respect to planned or future transactions, we cannot provide any assurances that we will be able to identify suitable candidates, consummate transactions on terms that are favorable to us, or achieve synergies or other benefits in a timely manner or at all. Furthermore, companies or operations we acquire may not be profitable or may not achieve the profitability that justifies the investments made. Businesses we acquire may also have pre-existing unknown or contingent liabilities, including liabilities for failure to comply with applicable healthcare regulations. These liabilities could be significant, and, if we are unable to exclude them from the acquisition transaction or successfully obtain indemnification from a third party, they could harm our business and financial condition. In addition, we may face significant challenges in integrating personnel and financial and other systems. Future acquisitions could result in the incurrence of additional debt and contingent liabilities, potentially dilutive issuances of equity securities, and increased operating expenses, any of which could adversely affect our results of operations and financial condition.

We cannot provide any assurances that we will be successful in divesting assets we wish to sell.

We continue to exit service lines, businesses and markets that we believe are no longer strategic to our long-term growth. To that end, since January 1, 2018, we have divested 11 acute care hospitals in the United States, as well as all of our operations in the United Kingdom. Furthermore, in December 2020, we entered into a definitive agreement to sell 87 UCCs from our Hospital Operations and Ambulatory Care segments to an unaffiliated independent urgent care provider, subject to regulatory approvals and customary closing conditions. We cannot provide any assurances that completed, planned or future divestitures or other strategic transactions will achieve their business goals or the benefits we expect.

With respect to all proposed divestitures of assets or businesses, we may fail to obtain applicable regulatory approvals for such divestitures. For example, in the three months ended December 31, 2020, the FTC took action to challenge our planned sale of two Tennessee hospitals to an unaffiliated third party; as a result, we determined in December 2020 that we no longer intend to pursue the transaction. Moreover, we may encounter difficulties in finding acquirers or alternative exit strategies on terms that are favorable to us, which could delay the receipt of anticipated proceeds necessary for us to complete our planned strategic objectives. In addition, our divestiture activities have required, and may in the future require, us to retain significant pre-closing liabilities, recognize impairment charges (as discussed above) or agree to contractual restrictions that limit our ability to reenter the applicable market, which may be material. Many of our acute care hospital divestitures also necessitate us entering into a transition services agreement with the applicable buyer for information technology and other related services. As a consequence, we may be exposed to the financial status of the buyer for any payments under such transition services agreements, which could be significant.

Furthermore, our divestiture and other corporate development activities, including the planned spin-off of Conifer (as discussed below), may present financial and operational risks, including (1) the diversion of management attention from existing core businesses, (2) adverse effects (including a deterioration in the related asset or business and, in Conifer's case, the loss of existing clients and the difficulties associated with securing new clients) from the announcement of the planned or potential activity, and (3) the challenges associated with separating personnel and financial and other systems.

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

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

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

As part of the formation of USPI in 2015, we entered into a put/call agreement with respect to the equity interests in USPI held by our joint venture partners at that time. During 2016, 2017 and 2018, we paid a total of $1.473 billion to purchase additional shares of USPI to increase our ownership interest in USPI from 50.1% to 95%.

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

Put and call arrangements, to the extent settled in cash, may require us to dedicate a substantial portion of our cash flow to satisfy our payment obligations in respect of such arrangements, which may reduce the amount of funds available for our operations, capital expenditures and corporate development activities. Similarly, we may be required to incur additional indebtedness to satisfy our payment obligations in respect of such arrangements, which could have important consequences to our business and operations, as described more fully below under "*Our level of indebtedness could, among other things,*

adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, and prevent us from meeting our obligations under the agreements relating to our indebtedness."

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

We have invested in a number of joint ventures with other entities when circumstances warranted the use of these structures, and we may form additional joint ventures in the future. These joint ventures may not be profitable or may not achieve the profitability that justifies the investments made. Furthermore, the nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit health systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our results could be adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our results could be adversely affected. In addition, our relationships with not-for-profit health systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current revenue rulings published by the Internal Revenue Service, as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit health systems and related joint venture arrangements.

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

- We could experience an impasse on certain decisions because we do not have sole decision-making authority, which could require us to expend additional resources on resolving such impasses or potential disputes.
- We may not be able to maintain good relationships with our joint venture partners (including health systems), which could limit our future growth potential and could have an adverse effect on our business strategies.
- Our joint venture partners could have investment or operational goals that are not consistent with our corporate-wide objectives, including the timing, terms and strategies for investments or future growth opportunities.
- Our joint venture partners might become bankrupt, fail to fund their share of required capital contributions or fail to fulfill their other obligations as joint venture partners, which may require us to infuse our own capital into any such venture on behalf of the related joint venture partner or partners despite other competing uses for such capital.
- Many of our existing joint ventures require that one of our wholly owned affiliates provide a working capital line of credit to the joint venture, which could require us to allocate substantial financial resources to the joint venture potentially impacting our ability to fund our other short-term obligations.
- Some of our existing joint ventures require mandatory capital expenditures for the benefit of the applicable joint venture, which could limit our ability to expend funds on other corporate opportunities.
- Our joint venture partners may have exit rights that would require us to purchase their interests upon the occurrence of certain events or the passage of certain time periods, which could impact our financial condition by requiring us to incur additional indebtedness in order to complete such transactions or, alternatively, in some cases we may have the option to issue shares of our common stock to our joint venture partners to satisfy such obligations, which would dilute the ownership of our existing shareholders. When our joint venture partners seek to exercise their exit rights, we may be unable to agree on the value of their interests, which could harm our relationship with our joint venture partners or potentially result in litigation.
- Our joint venture partners may have competing interests in our markets that could create conflict of interest issues.
- Any sale or other disposition of our interest in a joint venture or underlying assets of the joint venture may require consents from our joint venture partners, which we may not be able to obtain.

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

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

Risks Related to Conifer

We cannot provide any assurances that we will be successful in completing the proposed spin-off of Conifer.

We cannot predict the outcome of the process we have begun to pursue a tax-free spin-off of Conifer. We cannot provide any assurances regarding the timeframe for completing the spin-off, the allocation of assets and liabilities between Tenet and Conifer, that the other conditions of the spin-off will be met, or that the spin-off will be completed at all. We also cannot provide any assurances that the proposed spin-off of Conifer will achieve the business goals or the benefits we expect. Additional risks regarding our divestiture and other corporate development activities, including the planned spin-off of Conifer are described above under "We cannot provide any assurances that we will be successful in divesting assets in non-core markets."

A spin-off of Conifer could adversely affect our earnings and cash flows.

Conifer contributes a significant portion of the Company's earnings and cash flows. We have begun to pursue a tax-free spin-off of Conifer. Although there can be no assurance that this process will result in a consummated transaction, any separation of all or a portion of Conifer's business could adversely affect our earnings and cash flows.

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

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

Violations of existing regulations or failure to comply with new or changed regulations could harm Conifer's business and financial results.

Conifer and its subsidiaries are subject to numerous federal, state and local consumer protection and other laws governing such topics as privacy, financial services, and billing and collections activities. Regulations governing Conifer's operations are subject to changing interpretations that may be inconsistent among different jurisdictions. In addition, a regulatory determination made by, or a settlement or consent decree entered into with, one regulatory agency may not be binding upon, or preclude, investigations or regulatory actions by other agencies. Conifer's failure to comply with applicable consumer protection and other laws could result in, among other things, the issuance of cease and desist orders (which can include orders for restitution or rescission of contracts, as well as other kinds of affirmative relief), the imposition of fines or

refunds, and other civil and criminal penalties, some of which could be significant in the case of knowing or reckless violations. In addition, Conifer's failure to comply with the statutes and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its clients, give clients the right to terminate Conifer's services agreements with them or give rise to contractual liabilities, among other things, any of which could have a material adverse effect on Conifer's business. Furthermore, if Conifer or its subsidiaries become subject to fines or other penalties, it could harm Conifer's reputation, thereby making it more difficult for Conifer to retain existing clients or attract new clients.

Risks Related to Our Indebtedness

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, 2020, we had approximately $15.7 billion of total long-term debt, as well as $88 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 eligible inventory and patient accounts receivable, including receivables for Medicaid supplemental payments, 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 2020, our interest expense was $1.003 billion and represented 50% of our $1.989 billion of operating income. As a result, relatively small percentage changes in our operating income can result in a relatively large percentage change in our net income and earnings per share, both positively and negatively. In addition:

- Our substantial indebtedness may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt.
- We may be more vulnerable in the event of a deterioration in our business, in the healthcare industry or in the economy generally, or if federal or state governments substantially limit or reduce reimbursement under the Medicare or Medicaid programs.
- Our debt service obligations reduce the amount of funds available for our operations, capital expenditures and corporate development activities, and may make it more difficult for us to satisfy our financial obligations.
- Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.
- Our significant indebtedness may result in the market value of our stock being more volatile, potentially resulting in larger investment gains or losses for our shareholders, than the market value of the common stock of other companies that have a relatively smaller amount of indebtedness.
- A significant portion of our outstanding debt is subject to early prepayment penalties, such as "make-whole premiums"; as a result, it may be costly to pursue debt repayment as a deleveraging strategy.

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

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

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

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

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

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

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

- incur, assume or guarantee additional indebtedness;
- incur liens;
- make certain investments;
- provide subsidiary guarantees;
- consummate asset sales;
- redeem debt that is subordinated in right of payment to outstanding indebtedness;
- enter into sale and lease-back transactions;
- enter into transactions with affiliates; and
- consolidate, merge or sell all or substantially all of our assets.

These restrictions are subject to a number of important exceptions and qualifications. In addition, under certain circumstances, the terms of our Credit Agreement require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. Our ability to meet this financial ratio and the aforementioned restrictive covenants 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 or otherwise increase our leverage. This could further exacerbate the risks described above.

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

Our Credit Agreement provides for revolving loans in an aggregate principal amount of up to $1.9 billion, with a $200 million subfacility for standby letters of credit. Based on our eligible receivables, $1.9 billion was available for borrowing under the Credit Agreement at December 31, 2020. Our LC Facility provides for the issuance of standby and documentary letters of credit in an aggregate principal amount of up to $200 million. At December 31, 2020, we had no cash borrowings outstanding under the Credit Agreement, and we had $88 million of standby letters of credit outstanding in the aggregate under the Credit Agreement and the LC Facility. If new indebtedness is added or our leverage increases, the related risks that we now face could intensify.

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 17 to our Consolidated Financial Statements, which is incorporated by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II.

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

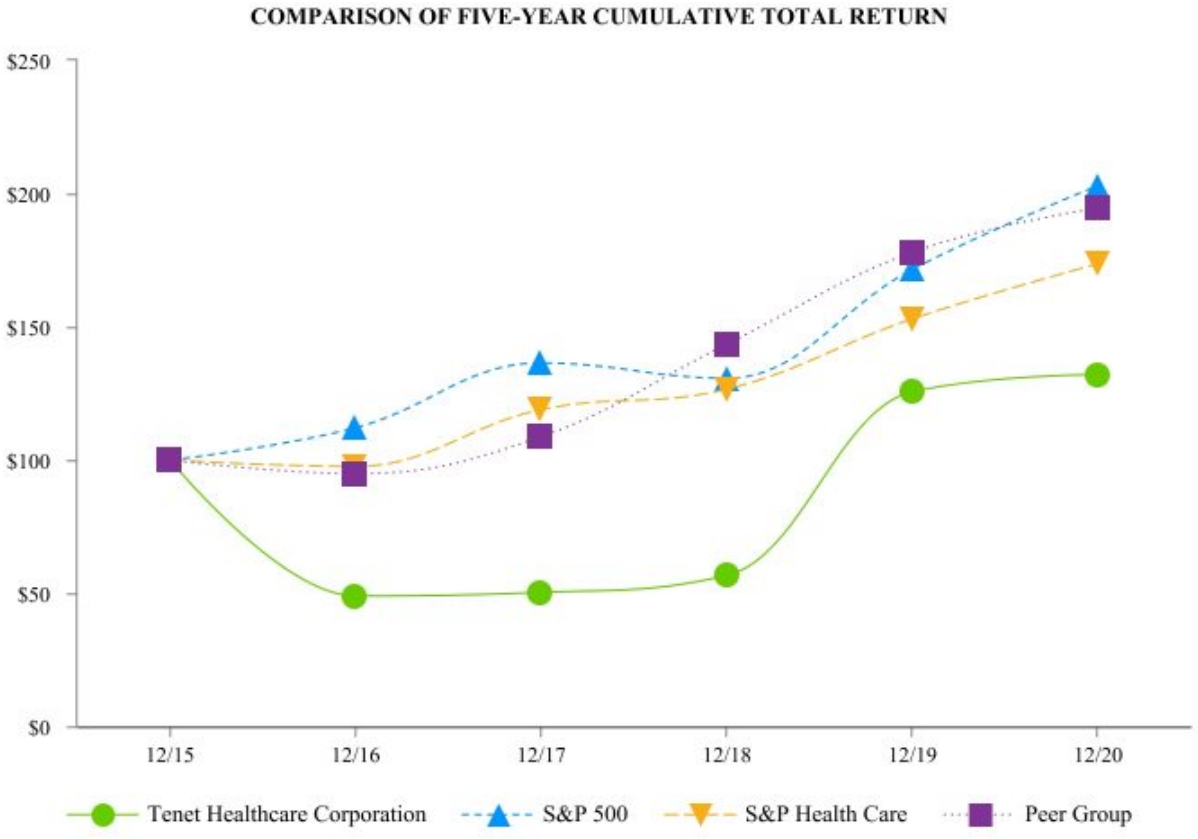
Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." As of February 12, 2021, there were 3,620 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

Equity Compensation. Refer to Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of Part III of this report, as well as Note 10 to our Consolidated Financial Statements, for information regarding securities authorized for issuance under our equity compensation plans.

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

- The S&P 500, a stock market index that measures the equity performance of 500 large companies listed on the stock exchanges in the United States (in which we are not included);
- The S&P 500 Health Care, a stock market index comprised of those companies included in the S&P 500 that are classified as part of the healthcare sector (in which we are not included); and
- A group made up of us and our hospital company peers (namely, Community Health Systems, Inc. (CYH), HCA Healthcare, Inc. (HCA), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS)), which we refer to as our "Peer Group".

Performance data assumes that $100.00 was invested on December 31, 2015 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Moreover, in accordance with U.S. Securities and Exchange Commission ("SEC") regulations, the returns of each company in our Peer Group have been weighted according to the respective company's stock market capitalization at the beginning of each period for which a return is indicated. The stock price performance shown in the graph is not necessarily indicative of future stock price performance. The performance graph shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or incorporated by reference into any of our filings under the Securities Act of 1933, as amended, or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.



	12/15	12/16	12/17	12/18	12/19	12/20
Tenet Healthcare Corporation	$ 100.00	$ 48.98	$ 50.03	$ 56.57	$ 125.51	$ 131.78
S&P 500	$ 100.00	$ 111.96	$ 136.40	$ 130.42	$ 171.49	$ 203.04
S&P Health Care	$ 100.00	$ 97.31	$ 118.79	$ 126.47	$ 152.81	$ 173.36
Peer Group	$ 100.00	$ 94.76	$ 108.52	$ 143.41	$ 177.85	$ 194.31

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. MD&A, which should be read in conjunction with the accompanying Consolidated Financial Statements, includes the following sections:

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

Our Hospital Operations and other ("Hospital Operations") segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. As described in Note 5 to the accompanying Consolidated Financial Statements, certain of these facilities were classified as held for sale at December 31, 2020 and 2019. Our Ambulatory Care segment is comprised of the operations of USPI Holding Company, Inc. ("USPI"), in which we own a 95% interest, and included nine European Surgical Partners Limited facilities until their divestiture effective August 17, 2018. At December 31, 2020, USPI had interests in 308 ambulatory surgery centers ("ASCs"), 40 urgent care centers, 24 imaging centers and 24 surgical hospitals in 31 states. As described in Note 5 to the accompanying Consolidated Financial Statements, certain of these facilities were classified as held for sale at December 31, 2020. Our Conifer segment provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients, through our Conifer Holdings, Inc. ("Conifer") subsidiary. Nearly all of the services comprising the operations of our Conifer segment are provided by Conifer Health Solutions, LLC, in which we owned a 76.2% interest as of December 31, 2020, or by one of its direct or indirect wholly owned subsidiaries.

As described in Note 1 to the accompanying Consolidated Financial Statements, our results for prior periods have been recast to reflect retrospective application of a change in accounting principle. 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 adjusted patient admission and per adjusted patient day amounts). Continuing operations information includes the results of our same 65 hospitals operated throughout the years ended December 31, 2020 and 2019, and the three Chicago-area hospitals we divested effective January 28, 2019. 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

Acquisition of Ambulatory Surgery Centers—In December 2020, we acquired controlling ownership interests in 45 ASCs (collectively, the "SCD Centers") from SurgCenter Development and physician owners for an aggregate purchase price of approximately $1.1 billion and the assumption of approximately $18 million of center-level debt. The transaction was fully funded with cash on hand separate from grant funds we have received from COVID-19 relief legislation, as described below. USPI will provide management services to each of the SCD Centers pursuant to the terms of management service agreements. The acquisition of the SCD Centers increased the number of USPI's ASCs by more than 15%. In addition, it significantly expanded USPI's presence in the musculoskeletal surgery market, a high-demand clinical service line. The SCD Centers complement our facilities in existing markets in Arizona, Florida and Texas, while also giving USPI a foothold in newer markets, such as Maryland and Wisconsin.

Definitive Agreement to Sell Urgent Care Platform—Also in December 2020, we entered into a definitive agreement to sell the majority of our urgent care centers operated under the MedPost and CareSpot brands to an unaffiliated independent urgent care provider. These facilities, along with related assets, were classified as held for sale in the accompanying

Consolidated Balance Sheet at December 31, 2020. We expect the transaction to be completed in the three months ending March 31, 2021, subject to regulatory approvals and customary closing conditions.

Redemption of Senior Unsecured Notes—In February 2021, we announced plans to redeem all $478 million aggregate principal amount outstanding of our 7.000% senior unsecured notes due 2025. We expect this redemption to result in annual interest savings of approximately $33 million.

IMPACT OF THE COVID-19 PANDEMIC

In 2020, the COVID-19 pandemic impacted all three segments of our business, as well as our patients, communities and employees. The spread of COVID-19 and the ensuing response of federal, state and local authorities beginning in March 2020 resulted in a material reduction in our patient volumes and also adversely affected our net operating revenues in the year ended December 31, 2020. In accordance with governmental mandates, from mid-March through early May 2020, we suspended elective procedures at many of our hospitals and ASCs; we also voluntarily reduced operating hours or temporarily closed some of our outpatient centers during this time. Restrictive measures, including travel bans, social distancing, quarantines and shelter-in-place orders, also reduced the number of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits. We began experiencing gradual and continued improvement in patient volumes in May 2020 as various states eased stay-at-home restrictions and our facilities were permitted to resume elective surgeries and other procedures. Broad economic factors resulting from the COVID-19 pandemic, including increased unemployment rates and reduced consumer spending, also impacted our patient volumes, service mix and revenue mix in the year ended December 31, 2020. The pandemic had an adverse effect on our operating expenses in 2020, as well. In some of our markets, we were required to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. We also experienced significant price increases in medical supplies, particularly for personal protective equipment. Moreover, we encountered supply chain disruptions, including shortages and delays. We continue to experience many of the aforementioned effects of the COVID-19 pandemic on our business in varying degrees.

As described under “Sources of Revenue for Our Hospital Operations Segment” below, various legislative actions have mitigated some of the economic disruption caused by the COVID-19 pandemic on our business. Additional funding for the Public Health and Social Services Emergency Fund (“Provider Relief Fund” or “PRF”) was among the provisions of the COVID-19 relief legislation. In the year ended December 31, 2020, we received cash payments of $974 million, and we recognized approximately $882 million and $17 million as grant income and in equity in earnings of unconsolidated affiliates, respectively, in our accompanying Consolidated Statements of Operations due to grants from the PRF and other state and local grant programs. In the year ended December 31, 2020, we also received advance payments of approximately $1.5 billion from the Medicare accelerated payment program due to the revisions to that program under COVID-19 relief legislation. We expect to repay these advances within the allocated recoupment period.

Throughout MD&A, we have provided additional information on the impact of the COVID-19 pandemic on our results of operations and the steps we have taken, and are continuing to take, in response. The ultimate extent and scope of the pandemic remains unknown. For information about risks and uncertainties around COVID-19 that could affect our results of operations, financial condition and cash flows, see the Risk Factors section in Part I of this report.

TRENDS AND STRATEGIES

As described above and throughout MD&A, we experienced a significant disruption to our business in 2020 due to the COVID-19 pandemic. Although we have seen gradual and continued improvement in our patient volumes since mid-year, we continue to experience negative impacts of the pandemic on our business in varying degrees, the length and extent of which are currently unknown. While demand for our services is expected to further rebound in the future, we have taken, and continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues from the pandemic. In the year ended December 31, 2020, we sold new senior notes and senior secured first lien notes, redeemed existing senior notes with the highest interest rate and nearest maturity date of all of our long-term debt, and amended our revolving credit facility, all as described below. We also reduced our planned capital expenditures for 2020 by approximately 25%. Furthermore, we decreased our employee headcount throughout the organization, and we deferred certain operating expenses that were not expected to impact our response to the COVID-19 pandemic. In addition, we reduced certain variable costs across the enterprise. We believe these actions, together with government relief packages, to the extent available to us, will help us to continue operating during the uncertainty caused by the COVID-19 pandemic. For further information on our liquidity, see “Liquidity and Capital Resources” below.

In recent years, the healthcare industry, in general, and the acute care hospital business, in particular, have also been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to

significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA"). It is difficult to predict the full impact of regulatory uncertainty on our future revenues and operations. In addition, we believe that several key trends have shaped the demand for healthcare services in recent years: (1) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (2) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (3) the growing aging population requires greater chronic disease management and higher-acuity treatment; and (4) consolidation continues across the entire healthcare sector.

Driving Growth in Our Hospital Systems—We are committed to better positioning our hospital systems and competing more effectively in the ever-evolving healthcare environment by focusing on driving performance through operational effectiveness, increasing capital efficiency and margins, investing in our physician enterprise, particularly our specialist network, enhancing patient and physician satisfaction, growing our higher-demand and higher-acuity clinical service lines (including outpatient lines), expanding patient and physician access, and optimizing our portfolio of assets. Over the past several years, we have undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions (including streamlining corporate overhead and centralized support functions), the renegotiation of contracts with suppliers and vendors, and the consolidation of office locations. Moreover, we established offshore support operations in the Philippines. In conjunction with these initiatives and our cost-saving efforts in response to the COVID-19 pandemic, we incurred restructuring charges related to employee severance payments of $65 million in the year ended December 31, 2020, and we expect to incur additional such restructuring charges in 2021.

We also continue to exit service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. In December 2020, we entered into a definitive agreement to sell the majority of our urgent care centers operated under the MedPost and CareSpot brands from our Hospital Operations and Ambulatory Care segments. We intend to continue to further refine our portfolio of hospitals and other healthcare facilities when we believe such refinements will help us improve profitability, allocate capital more effectively in areas where we have a stronger presence, deploy proceeds on higher-return investments across our business, enhance cash flow generation, reduce our debt and lower our ratio of debt-to-Adjusted EBITDA.

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

Expansion of Our Ambulatory Care Segment—We continue to focus on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. In December 2020, we acquired controlling ownership interests in the SCD Centers, which significantly increased USPI's presence in the musculoskeletal surgery market, a high-demand clinical service line, particularly for an aging population. We also acquired controlling interests in seven additional ASCs and one imaging center, opened two new ASCs and opened one urgent care center during the year ended December 31, 2020. We believe USPI's ASCs and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability, flexibility and convenience. Moreover, due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable at a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to increase following the containment of the COVID-19 pandemic. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

Driving Conifer's Growth While Pursuing a Tax-Free Spin-Off—We previously announced a number of actions to support our goals of improving financial performance and enhancing shareholder value, including the exploration of strategic alternatives for Conifer. In July 2019, we announced our intention to pursue a tax-free spin-off of Conifer as a separate, independent, publicly traded company. Completion of the proposed spin-off is subject to a number of conditions, including, among others, assurance that the separation will be tax-free for U.S. federal income tax purposes, execution of a restructured long-term services agreement between Conifer and Tenet, finalization of Conifer's capital structure, the effectiveness of appropriate filings with the SEC, and final approval from our board of directors. Although we are continuing to pursue the

Conifer spin-off, there can be no assurance regarding the timeframe for completion, the allocation of assets and liabilities between Tenet and Conifer, that the other conditions of the spin-off will be met, or that it will be completed at all.

Conifer serves approximately 630 Tenet and non-Tenet hospital and other clients nationwide. In addition to providing revenue cycle management services to health systems and physicians, Conifer provides support to both providers and self-insured employers seeking assistance with clinical integration, financial risk management and population health management. Conifer remains focused on driving growth by continuing to market and expand its revenue cycle management and value-based care solutions businesses. We believe that our success in growing Conifer and increasing its profitability depends in part on our success in executing the following strategies: (1) attracting hospitals and other healthcare providers that currently handle their revenue cycle management processes internally as new clients; (2) generating new client relationships through opportunities from USPI and Tenet's acute care hospital acquisition and divestiture activities; (3) expanding revenue cycle management and value-based care service offerings through organic development and small acquisitions; and (4) leveraging data from tens of millions of patient interactions for continued enhancement of the value-based care environment to drive competitive differentiation.

Improving Profitability—As we return to more normal operations, we will continue to focus on growing patient volumes and effective cost management as a means to improve profitability. We believe our inpatient admissions have been constrained in recent years (prior to the COVID-19 pandemic) by increased competition, utilization pressure by managed care organizations, new delivery models that are designed to lower the utilization of acute care hospital services, the effects of higher patient co-pays, co-insurance amounts and deductibles, changing consumer behavior, and adverse economic conditions and demographic trends in certain of our markets. However, we also believe that emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our ambulatory care business, cultivation of our culture of service, participation in Medicare Advantage health plans that have been experiencing higher growth rates than traditional Medicare, and contracting strategies that create shared value with payers should help us grow our patient volumes over time. We are also continuing to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing additional functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

Reducing Our Leverage Over Time—All of our outstanding long-term debt has a fixed rate of interest, except for outstanding borrowings under our revolving credit facility, and the maturity dates of our notes are staggered from 2023 through 2031. We believe that our capital structure minimizes the near-term impact of increased interest rates, and the staggered maturities of our debt allow us to refinance our debt over time. Although we issued $1.300 billion aggregate principal amount of senior secured first lien notes in 2020 to manage our liquidity during the COVID-19 pandemic, it is nonetheless our long-term objective to reduce our debt and lower our ratio of debt-to-Adjusted EBITDA, primarily through more efficient capital allocation and Adjusted EBITDA growth, which should lower our refinancing risk. Moreover, in 2020, we sold $2.500 billion aggregate principal amount of senior notes to finance the redemption of senior notes with the highest interest rate and nearest maturity date of all of our long-term debt. These transactions eliminated any significant debt maturities until June 2023, as well as reduced future annual cash interest expense payments by approximately $50 million.

Our ability to execute on our strategies and respond to the aforementioned trends is subject to the extent and scope of the impact on our operations of the COVID-19 pandemic, as well as a number of other risks and uncertainties, all of which may cause actual results to be materially different from expectations. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

RECENT RESULTS OF OPERATIONS

We have provided below certain selected operating statistics for the three months ended December 31, 2020 and 2019 on a continuing operations basis, which includes the results of our same 65 hospitals operated throughout the three months ended December 31, 2020 and 2019 and the three Chicago-area hospitals we divested effective January 28, 2019. The following tables also show information about facilities in our Ambulatory Care segment that we control and, therefore, consolidate. 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. We present certain metrics on a per adjusted patient admission basis to show trends other than volume.

	Continuing Operations Three Months Ended December 31,		
Selected Operating Statistics	**2020**	**2019**	**Increase (Decrease)**
Hospital Operations – hospitals and related outpatient facilities:			
Number of hospitals (at end of period)	65	65	— (1)
Total admissions	152,694	170,815	(10.6)%
Adjusted patient admissions(2)	261,097	306,384	(14.8)%
Paying admissions (excludes charity and uninsured)	143,195	160,244	(10.6)%
Charity and uninsured admissions	9,499	10,571	(10.1)%
Admissions through emergency department	114,887	122,339	(6.1)%
Emergency department visits, outpatient	466,179	645,791	(27.8)%
Total emergency department visits	581,066	768,130	(24.4)%
Total surgeries	95,467	106,399	(10.3)%
Patient days — total	790,522	796,239	(0.7)%
Adjusted patient days(2)	1,322,063	1,394,191	(5.2)%
Average length of stay (days)	5.18	4.66	11.2 %
Average licensed beds	17,203	17,211	— %
Utilization of licensed beds(3)	49.9 %	50.3 %	(0.4)% (1)
Total visits	1,441,157	1,700,696	(15.3)%
Paying visits (excludes charity and uninsured)	1,350,576	1,586,704	(14.9)%
Charity and uninsured visits	90,581	113,992	(20.5)%
Ambulatory Care:			
Total consolidated facilities (at end of period)	290	238	52 (1)
Total cases	566,519	549,319	3.1 %

(1) The change is the difference between the 2020 and 2019 amounts shown.

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations 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 18,121, or 10.6%, in the three months ended December 31, 2020 compared to the three months ended December 31, 2019, and total surgeries decreased by 10,932, or 10.3%, in the 2020 period compared to the 2019 period. Total emergency department visits decreased 24.4% in the three months ended December 31, 2020 compared to the same period in the prior year. The decrease in our patient volumes from continuing operations in the three months ended December 31, 2020 compared to the three months ended December 31, 2019 reflects the continued adverse impact of the COVID-19 pandemic. Our Ambulatory Care total cases increased 3.1% in the three months ended December 31, 2020 compared to the 2019 period.

	Continuing Operations Three Months Ended December 31,		
Revenues	**2020**	**2019**	**Increase (Decrease)**
Net operating revenues			
Hospital Operations prior to inter-segment eliminations	$ 4,065	$ 3,983	2.1 %
Ambulatory Care	649	632	2.7 %
Conifer	344	332	3.6 %
Inter-segment eliminations	(143)	(141)	1.4 %
Total	**$ 4,915**	**$ 4,806**	**2.3 %**

Net operating revenues increased by $109 million, or 2.3%, in the three months ended December 31, 2020 compared to the same period in 2019, primarily due to higher patient acuity, a more favorable payer mix, incremental revenue from new service lines, and improved terms of our managed care contracts, partially offset by the impact of lower patient volumes as a result of the COVID-19 pandemic. During the three months ended December 31, 2020, our Hospital Operations and Ambulatory Care segments were also impacted by the revised grant guidelines included in the Consolidated Appropriations Act, 2021, which was enacted on December 28, 2020, and the receipt of additional grant funds during the period primarily by our Ambulatory Care segment. As a result, our Hospital Operations and Ambulatory Care segments recognized grant income from federal, state and local programs totaling $406 million and $40 million ($9 million of which is included in equity in earnings of unconsolidated affiliates), respectively, in the three months ended December 31, 2020, which amounts are not included in net operating revenues.

Our accounts receivable days outstanding ("AR Days") from continuing operations were 55.6 days at December 31, 2020 and 58.4 days at December 31, 2019, compared to our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last day of the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter. This calculation includes our Hospital Operations contract assets, as well as the accounts receivable of the facilities in our urgent care platform that have been classified in assets held for sale on our Consolidated Balance Sheet at December 31, 2020, and excludes (i) three Chicago-area hospitals we divested effective January 28, 2019, and (ii) our California provider fee revenues.

	Continuing Operations Three Months Ended December 31,		
Selected Operating Expenses	**2020**	**2019**	**Increase (Decrease)**
Hospital Operations			
Salaries, wages and benefits	$ 1,892	$ 1,887	0.3 %
Supplies	674	670	0.6 %
Other operating expenses	910	887	2.6 %
Total	$ 3,476	$ 3,444	0.9 %
Ambulatory Care			
Salaries, wages and benefits	$ 171	$ 168	1.8 %
Supplies	149	132	12.9 %
Other operating expenses	91	86	5.8 %
Total	$ 411	$ 386	6.5 %
Conifer			
Salaries, wages and benefits	$ 162	$ 175	(7.4) %
Supplies	1	1	— %
Other operating expenses	70	62	12.9 %
Total	$ 233	$ 238	(2.1) %
Total			
Salaries, wages and benefits	$ 2,225	$ 2,230	(0.2) %
Supplies	824	803	2.6 %
Other operating expenses	1,071	1,035	3.5 %
Total	$ 4,120	$ 4,068	1.3 %
Rent/lease expense(1)			
Hospital Operations	$ 74	$ 62	19.4 %
Ambulatory Care	25	23	8.7 %
Conifer	3	2	50.0 %
Total	$ 102	$ 87	17.2 %

(1) Included in other operating expenses.

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended December 31, 2020	2019	Increase (Decrease)
Hospital Operations			
Salaries, wages and benefits per adjusted patient admission[1]	$ 7,244	$ 6,156	17.7 %
Supplies per adjusted patient admission[1]	2,583	2,190	17.9 %
Other operating expenses per adjusted patient admission[1]	3,480	2,885	20.6 %
Total per adjusted patient admission	$ 13,307	$ 11,231	18.5 %

(1) Calculation excludes the expenses from our health plan businesses. Adjusted patient admissions represents actual patient admissions adjusted to include outpatient services provided by facilities in our Hospital Operations 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 for our Hospital Operations segment increased $5 million, or 0.3%, in the three months ended December 31, 2020 compared to the same period in 2019. This change was primarily due to increased health benefits costs, an increased average length of patient stay, and the impact of higher temporary labor and premium pay, as well as annual merit increases for certain of our employees, a greater number of employed physicians and increased incentive compensation expense in the three months ended December 31, 2020 compared to the three months ended December 31, 2019. Our continued focus on strategic cost-reduction and efficiency measures partially mitigated the impact of the COVID-19 surges in our markets in the three months ended December 31, 2020. On a per adjusted patient admission basis, salaries, wages and benefits increased 17.7% in the three months ended December 31, 2020 compared to the three months ended December 31, 2019 primarily due to reduced patient volumes as a result of the COVID-19 pandemic.

Supplies expense for our Hospital Operations segment increased $4 million, or 0.6%, in the three months ended December 31, 2020 compared to the same period in 2019. This change was primarily attributable to increased costs for certain supplies as a result of the COVID-19 pandemic, as well as 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. On a per adjusted patient admission basis, supplies expense increased 17.9% in the three months ended December 31, 2020 compared to the three months ended December 31, 2019 primarily due to reduced patient volumes as a result of the pandemic.

Other operating expenses for our Hospital Operations segment increased $23 million, or 2.6%, in the three months ended December 31, 2020 compared to the same period in 2019. This increase was primarily due to higher medical fees, increased rent expense and higher information technology costs, partially offset by a gain on asset sales in the 2020 period related to the divestiture of a medical office building. There is proportionally a higher level of fixed costs (e.g., rent expense) in other operating expenses than salaries, wages and benefits or supplies expense. On a per adjusted patient admission basis, other operating expenses increased 20.6% in the three months ended December 31, 2020 compared to the three months ended December 31, 2019 due to reduced patient volumes as a result of the COVID-19 pandemic.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $2.446 billion at December 31, 2020 compared to $3.300 billion at September 30, 2020.

Significant cash flow items in the three months ended December 31, 2020 included:

- Net cash provided by operating activities before interest, taxes, discontinued operations and restructuring charges, acquisition-related costs, and litigation costs and settlements of $734 million, including $52 million of cash received from federal, state and local grants;
- Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements of $81 million;
- Capital expenditures of $166 million;
- $1.116 billion of payments for the purchases of businesses or joint venture interests;
- Proceeds from sales of facilities and other assets of $64 million;

- Interest payments of $205 million; and
- $103 million of distributions paid to noncontrolling interests.

Net cash provided by operating activities was $3.407 billion in the year ended December 31, 2020 compared to $1.233 billion in the year ended December 31, 2019. Key factors contributing to the change between the 2020 and 2019 periods include the following:

- Approximately $1.4 billion of cash advances received from Medicare pursuant to COVID-19 stimulus legislation;
- $900 million of cash received from federal, state and local grants, including the Provider Relief Fund;
- A $260 million deferral of our payroll tax match in 2020 pursuant to COVID-19 stimulus legislation;
- Decreased cash receipts of $81 million related to supplemental Medicaid programs in California and Texas;
- Higher interest payments of $16 million in the 2020 period;
- An increase of $141 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- The timing of other working capital items.

SOURCES OF REVENUE FOR OUR HOSPITAL OPERATIONS SEGMENT

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

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

	Years Ended December 31,		
Net Patient Service Revenues Less Implicit Price Concessions from:	**2020**	**2019**	**2018**
Medicare	19.8 %	20.1 %	20.5 %
Medicaid	7.9 %	8.3 %	9.2 %
Managed care(1)	66.3 %	66.2 %	65.4 %
Uninsured	1.2 %	0.7 %	0.7 %
Indemnity and other	4.8 %	4.7 %	4.2 %

(1) Includes Medicare and Medicaid managed care programs.

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

	Years Ended December 31,		
Admissions from:	**2020**	**2019**	**2018**
Medicare	22.8 %	24.8 %	25.4 %
Medicaid	6.2 %	6.2 %	6.3 %
Managed care(1)	61.8 %	60.3 %	59.7 %
Charity and uninsured	6.3 %	6.0 %	6.0 %
Indemnity and other	2.9 %	2.7 %	2.6 %

(1) Includes Medicare and Medicaid managed care programs.

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 61 million individuals rely on healthcare benefits through Medicare, and approximately 77 million individuals are enrolled in Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and administered by CMS. Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, as well as some younger people with certain disabilities and conditions, and is provided without regard to income or assets. Medicaid is co-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 co-administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage. Unlike Medicaid, the CHIP is limited in duration and requires the enactment of reauthorizing legislation. Funding for the CHIP has been reauthorized through federal fiscal year ("FFY") 2027.

The Affordable Care Act

The expansion of Medicaid in the 38 states (including four in which we currently operate acute care hospitals) and the District of Columbia that have taken action to do so is financed through:

- negative adjustments to the annual market basket updates for the Medicare hospital inpatient and outpatient prospective payment systems, which began in 2010 and expired on September 30, 2019, as well as additional negative "productivity adjustments" to the annual market basket updates, which began in 2011 and do not expire under current law; and

- reductions to Medicare and Medicaid disproportionate share hospital ("DSH") payments, which began for Medicare payments in FFY 2014 and, under current law, are scheduled to commence for Medicaid payments in FFY 2024.

Effective January 2019, Congress eliminated the financial penalty for noncompliance under the ACA's individual mandate provision, which requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards. On November 10, 2020, the U.S. Supreme Court heard oral arguments in the matter of *California v. Texas* addressing whether the individual mandate itself is unconstitutional now that Congress has eliminated the tax penalty that was intended to enforce it. Conversely, members of Congress and other politicians have proposed measures that would expand government-sponsored coverage, including single-payer plans, such as Medicare for All. We cannot predict whether the U.S. Supreme Court's decision will invalidate the Affordable Care Act, nor can we predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

Furthermore, we are unable to predict the impact on our future revenues and operations of (1) the final decision in *California v. Texas* and other court challenges to the ACA, (2) administrative, regulatory and legislative changes, including expansion of government-sponsored coverage, or (3) market reactions to those changes. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased patient volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service ("FFS") 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 FFS Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient service revenues from continuing operations of the hospitals and related outpatient facilities in our Hospital Operations segment for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2020, 2019 and 2018 are set forth in the following table:

Revenue Descriptions	Years Ended December 31, 2020	2019	2018
Medicare severity-adjusted diagnosis-related group — operating	$ 1,411	$ 1,512	$ 1,526
Medicare severity-adjusted diagnosis-related group — capital	121	133	137
Outliers	64	82	83
Outpatient	635	737	748
Disproportionate share	210	232	228
Other(1)	254	192	160
Total Medicare net patient service revenues	**$ 2,695**	**$ 2,888**	**$ 2,882**

(1) The other revenue category includes Medicare Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") revenues, IME revenues earned by our children's hospitals (one of which we divested in 2018) under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS, inpatient psychiatric units, inpatient rehabilitation units, other revenue adjustments, and adjustments to the estimates for current and prior-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 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, changes in labor data by geographic area, and other policies. 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 updated annually by CMS. A Medicare Administrative Contractor ("MAC") calculates the cost of a claim by multiplying the billed charges by an average 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 Social Security 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. Under certain conditions, outlier payments are subject to reconciliation based on more recent data.

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 based on each hospital's low income utilization for each payment year (the "Pre-ACA DSH Formula"). The ACA revised the Medicare DSH adjustment effective for discharges occurring on or after

October 1, 2013. Under the revised methodology, hospitals receive 25% of the amount they previously would have received under the Pre-ACA DSH Formula. This amount is referred to as the "Empirically Justified Amount."

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC-DSH Amount"). The UC-DSH Amount is a hospital's share of a pool of funds that the CMS Office of the Actuary estimates would equal 75% of Medicare DSH that otherwise would have been paid under the Pre-ACA DSH Formula, adjusted for changes in the percentage of individuals that are uninsured. Generally, the factors used to calculate and distribute UC-DSH Amounts are set forth in the ACA and are not subject to administrative or judicial review. The statute requires that each hospital's cost of uncompensated care (i.e., charity and bad debt) as a percentage of the total uncompensated care cost of all DSH hospitals be used to allocate the pool. As of December 31, 2020, 57 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. We are unable to predict what action the Secretary might take with respect to the DSH calculation for prior periods in this regard or the outcome of the pending litigation; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for the increased expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of DGME and IME payments. As of December 31, 2020, 29 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments.

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

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

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

Hospital Outpatient Prospective Payment System

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

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility ("IPF") prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient prospective payment system. The IPF-PPS is based on prospectively determined per-diem rates and includes an outlier policy that authorizes additional payments for extraordinarily costly cases. As of December 31, 2020, 17 of our general hospitals in continuing operations operated IPF units.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system. As of December 31, 2020, we operated one freestanding IRF, and 15 of our general hospitals in continuing operations operated IRF units.

Physician and Other Health Professional Services Payment System

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

Cost Reports

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

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

Medicare Claims Reviews

HHS estimates that the overall FFY 2020 Medicare FFS improper payment rate for the program is approximately 6.3%. The FFY 2020 error rate for Hospital IPPS payments is approximately 3.0%. 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 Social Security Act, CMS employs a variety of contractors (e.g., MACs, Recovery Audit Contractors and Unified Program Integrity Contractors) to process and review claims according to Medicare rules and regulations.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment and post-payment claims denials are subject to administrative and judicial review, and we intend to pursue the reversal of adverse determinations where appropriate. We have established robust protocols to respond to claims reviews and payment denials. In addition to overpayments that are not reversed on appeal, we 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.

Meaningful Use of Health Information Technology

The Health Information Technology for Economic and Clinical Health ("HITECH") Act, which is part of the American Recovery and Reinvestment Act of 2009, promotes the use of healthcare information technology by, among other things, providing financial incentives to hospitals and physicians to become "meaningful users" of electronic health record ("EHR") systems and imposing penalties on those who do not. Under the HITECH Act and other laws and regulations, eligible

hospitals that fail to demonstrate and maintain meaningful use of certified EHR technology every year (and have not applied and qualified for a hardship exception) are subject to a 75% reduction of the Medicare market basket update. Eligible healthcare professionals are also subject to positive or negative payment adjustments based, in part, on their use of EHR technology. We have made significant investments in our information systems to bring our hospitals and employed physicians into EHR compliance, and we continue to invest in the maintenance and utilization of these certified EHR systems. Failure to continue to do so could subject us to penalties that may have an adverse effect on our net revenues and results of operations.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded Medicaid managed care programs, constituted approximately 17.8%, 18.4% and 19.8% of total net patient service revenues less implicit price concessions of our acute care hospitals and related outpatient facilities for the years ended December 31, 2020, 2019 and 2018, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the years ended December 31, 2020, 2019 and 2018, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately $754 million, $782 million and $847 million, respectively. The 2020 period included $239 million related to the California provider fee program, $230 million related to the Michigan provider fee program, $164 million related to Medicaid DSH programs in multiple states, $55 million related to the Texas Section 1115 waiver program, and $66 million from a number of other state and local programs.

Even prior to the COVID-19 pandemic, several states in which we operate faced budgetary challenges that resulted 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 supplemental payment programs authorized under the Social Security Act. Continuing pressure on state budgets and other factors could adversely affect the Medicaid supplemental payments our hospitals receive.

Because we cannot predict what actions the federal government or the states may take under existing or future legislation and/or regulatory changes 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 or regulatory action might have on our business; however, the impact on our future financial position, results of operations or cash flows could be material.

Medicaid and Managed Medicaid net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations segment from Medicaid-related programs in the states in which our facilities are (or were, as the case may be) located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2020, 2019 and 2018 are set forth in the following table. These revenues are presented net of provider taxes or assessments paid by our hospitals, which are reported as an offset reduction to FFS Medicaid revenue.

	Years Ended December 31,		
Hospital Location	**2020**	**2019**	**2018**
Alabama	$ 103	$ 91	$ 91
Arizona	178	159	165
California	827	855	875
Florida	201	222	231
Illinois	—	5	89
Massachusetts	83	92	94
Michigan	560	714	749
Pennsylvania	—	—	8
South Carolina	58	55	53
Tennessee	35	37	35
Texas	382	409	398
	$ 2,427	**$ 2,639**	**$ 2,788**

Medicaid and Managed Medicaid revenues comprised 45% and 55%, respectively, of our Medicaid-related net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations segment for the year ended December 31, 2020.

Regulatory and Legislative Changes

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

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Section 1886(d) of the Social Security Act requires CMS to update inpatient FFS payment rates for hospitals reimbursed under the IPPS annually. The updates generally become effective October 1, the beginning of the federal fiscal year. In September 2020 and in a December 2020 correction notice, CMS issued the final Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2021 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.4% for MS-DRG operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record technology; CMS also finalized certain proposed adjustments to the 2.4% market basket increase that resulted in a net operating payment update of 2.9% (before budget neutrality adjustments), as follows:
    - No multifactor productivity adjustment under the ACA (i.e., an adjustment of 0.0%) for FFY 2021; and
    - A 0.5% increase, as required under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA");
- Updates to the three factors used to determine the amount and distribution of Medicare UC-DSH Amounts;
- A 0.84% net increase in the capital federal MS-DRG rate; and
- An increase in the cost outlier threshold from $26,552 to $29,064.

According to CMS, the combined impact of the payment and policy changes in the Final IPPS Rule for operating costs will yield an average 2.5% increase in Medicare operating MS-DRG FFS payments for hospitals in urban areas, and an average 2.4% increase in operating MS-DRG FFS payments for proprietary hospitals in FFY 2021. We estimate that all of the payment and policy changes affecting operating MS-DRG and UC-DSH Amounts will result in an estimated 1.8% increase in our annual Medicare FFS IPPS payments, which yields an estimated increase of approximately $37 million. Because of the uncertainty associated with various factors that may influence our future IPPS payments by individual hospital, including legislative, regulatory or legal actions, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

Historically, CMS has used charges reduced to cost to set the relative weights assigned to each MS-DRG. In the Final IPPS Rule, CMS expressed a concern that chargemaster rates rarely reflect the true market costs. In order to reduce its reliance on the hospital chargemaster, CMS determined that, beginning in 2021, hospitals will be required to report in the annual cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage payers by MS-DRG. This information may potentially be used to set the IPPS MS-DRG relative weights in FFY 2024. This standard is in addition to the pricing transparency requirements effective January 1, 2021 in the hospital price transparency final rule issued in November 2019 that was upheld by a federal District Court. In December 2020, the U.S. Court of Appeals for the District of Columbia affirmed the federal District Court's decision.

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

In December 2020, CMS released the policy changes and payment rates for the Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center Payment System for calendar year ("CY") 2021 ("Final OPPS/ASC Rule"). The Final OPPS/ASC Rule includes the following payment and policy changes:

- A net increase of 2.4% for the OPPS rates based on a market basket increase of 2.4% with no multifactor productivity adjustment required by the ACA (i.e., an adjustment of 0.0% for CY 2021);
- A continuation of the reduced payment amount for drugs acquired with a discount under CMS' 340B program ("340B Drugs") to a rate of average sales price ("ASP") minus 22.5% (the 340B program is the subject of litigation discussed in greater detail below);
- Elimination of the Inpatient Only List (which is the list of procedures that must be performed on an inpatient basis) over a transitional period beginning in CY 2021 and ending in CY 2024, starting with the removal of 266 musculoskeletal services from the list for CY 2021;
- The addition of two new OPPS service categories for which prior authorization is required; and
- A 2.4% increase to the Ambulatory Surgical Center payment rates.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS/ASC Rule will yield an average 2.4% increase in Medicare FFS OPPS payments for hospitals in urban areas and an average 3.2% increase in Medicare FFS OPPS payments for proprietary hospitals. Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS/ASC Rule on our hospitals is an increase to Medicare FFS hospital outpatient revenues of approximately $24 million, which represents an increase of approximately 3.6%. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative or legal actions, volumes and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

The Medicare Access and CHIP Reauthorization Act of 2015

The MACRA replaced the Medicare Sustainable Growth Rate methodology with a new system for establishing the annual updates to the MPFS beginning in 2019. The new payment system helps to link FFS payments to quality and value with payment incentives and penalties. Additionally, the MACRA reduced the restoration of the 3.2% coding and document adjustment to hospital inpatient rates that was expected to be effective in FFY 2018 to 3.0%; as modified by the 21st Century Cures Act, the adjustment was applied at the rate of 0.5% for FFY 2018 and 0.5% for FFYs 2019 and 2020; it will continue to be applied at the rate of 0.5% through 2023.

Less than 1% of the net operating revenue generated by our Hospital Operations segment during the year ended 2020 was related to the MPFS. We are unable to estimate the potential impact of the MACRA; however, the maximum incentive and penalty adjustments could result in an increase or decrease in our annual net revenues of approximately $15 million. Additionally, we cannot predict the effect of the MACRA on our future operations, revenues and cash flows.

Payment and Policy Changes to the Medicare Physician Fee Schedule

In December 2020, CMS released the CY 2021 MPFS Final Rule which updates payment policies, payment rates and other provisions for services reimbursed under the MPFS on and after January 1, 2021. The statutory update factor to the MPFS conversion factor (the base rate that is used to convert relative value units ("RVUs") into payment rates) for CY 2021, as required by the MACRA, was set at 0.0%. The final conversion factor also reflects a negative budget neutrality adjustment of 10.20% to account for the estimated positive or negative effects of the changes on each specialty due to, among other things, CMS' projection of volumes in each specialty and the recalibration of the RVUs. CMS estimates that the combined impact of the payment and policy changes in the MPFS Final Rule will not result in any change in payments. The Consolidated Appropriations Act, 2021 provides a one-time 3.75% increase in MPFS payments for CY 2021.

The Coronavirus Aid, Relief, and Economic Security Act of 2020 and Related Legislation

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which was signed into law on March 27, 2020, the Paycheck Protection Program and Health Care Enhancement Act (the "PPP Act"), which was signed into law on April 24, 2020, the Continuing Appropriations Act, 2021 and Other Extensions Act (the "Continuing Appropriations Act"), which was signed into law October 1, 2020, and the Consolidated Appropriations Act, 2021 (the "Consolidated Appropriations Act" and, collectively, with the CARES Act, the PPP Act, and the Continuing Appropriations Act, the "COVID Acts"), which was signed into law on December 27, 2020 authorized $2.9 trillion in government spending to mitigate the economic effects of the COVID-19 pandemic. Below is a brief overview of certain provisions of these laws that have impacted, and that we expect will continue to impact, our business. This summary is not exhaustive, and additional legislative action and regulatory developments may evolve rapidly. There is no assurance that we will continue to receive or remain eligible for funding or assistance under the COVID Acts or similar measures. Statements regarding the projected impact of COVID-19 relief programs on our operations and financial condition are forward-looking and are made as of the date of this filing.

Public Health and Social Services Emergency Fund—The COVID Acts have authorized $178 billion in payments to be distributed through the Provider Relief Fund. Distributions from the PRF to providers commenced during the three months ended June 30, 2020. Payments from the PRF are not loans and, therefore, they are not subject to repayment. However, as a condition to receiving distributions, providers must agree to certain terms and conditions, including, among other things, that the funds are being used for lost revenues and unreimbursed COVID-related costs as defined by HHS, and that the providers will not seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. All recipients of PRF payments are required to comply with the reporting requirements described in the terms and conditions and as determined by HHS. In January 2021, HHS released updated reporting requirements that include lost revenues, expenses attributable to COVID-19 and non-financial information. The updated reporting requirements reflect certain provisions of the Consolidated Appropriations Act affecting the calculation of lost revenues, as well as the distribution of PRF funds among subsidiaries in a hospital system. Furthermore, HHS has indicated that it will be closely monitoring and, along with the Office of Inspector General, auditing providers to ensure that recipients comply with the terms and conditions of relief programs and to prevent fraud and abuse. All providers will be subject to civil and criminal penalties for any deliberate omissions, misrepresentations or falsifications of any information given to HHS. Except for certain immaterial PRF payments we returned to HHS, we have formally accepted PRF payments issued to our providers and the terms and conditions associated with those payments.

During the year ended December 31, 2020, our Hospital Operations and Ambulatory Care segments recognized approximately $868 million of Provider Relief Fund income associated with lost revenues and COVID-related costs. We recognized an additional $17 million of Provider Relief Fund income from our unconsolidated affiliates during this period. Lastly, our Hospital Operations and Ambulatory Care segments recognized $14 million of grant income from state and local grant programs during 2020. Grant income recognized by our Hospital Operations and Ambulatory Care segments is presented in grant income and grant income recognized through our unconsolidated affiliates is presented in equity in earnings of unconsolidated affiliates in the accompanying Consolidated Statements of Operations for the year ended December 31, 2020. Based on the uncertainty regarding future estimates of lost revenues and COVID-related costs or the impact of further updates to HHS guidance, if any, we cannot provide any assurances regarding the amount of grant income to be recognized in the future.

Medicare and Medicaid Payment Policy Changes—The COVID Acts also alleviate some of the financial strain on hospitals, physicians, other healthcare providers and states through a series of Medicare and Medicaid payment policies that temporarily increase Medicare and Medicaid reimbursement and allow for added flexibility, as described below:

- Effective May 1, 2020 through March 31, 2021, the 2% sequestration reduction on Medicare FFS and Medicare Advantage payments to hospitals, physicians and other providers is suspended and is scheduled to resume effective April 2021. The impact of this change on our operations was an increase of approximately $67 million of revenues in 2020.

- The CARES Act instituted a 20% increase in the Medicare MS-DRG payment for COVID-19 hospital admissions for the duration of the public health emergency as declared by the Secretary of HHS.

- The CARES Act eliminated the scheduled nationwide reduction of $4 billion in federal Medicaid DSH allotments in FFY 2020 mandated by the Affordable Care Act and decreased the FFY 2021 DSH reduction from $8 billion to $4 billion effective December 1, 2020. Later COVID Acts eliminated the FFY 2021 DSH reduction entirely and delayed the remaining DSH reductions until FFY 2024.

- The CARES Act expanded the Medicare accelerated payment program, which provides prepayment of claims to providers in certain circumstances, such as national emergencies or natural disasters. Under this measure, providers could request accelerated payments during which time providers continue to receive payments for services. Under the CARES Act, accelerated payments could be retained for 120 days; at the end of the 120-day period, the accelerated payment would be repaid via an offset of payments on claims that would otherwise be paid. Generally, repayments of the accelerated payments we received were to commence during the three months ended September 2020; however, under Section 2501 of the Continuing Appropriations Act, providers may retain the accelerated payments for one year from the date of receipt before CMS commences recoupment, which will be effectuated by a 25% offset of claims payments for 11 months, followed by 50% offset for the succeeding six months. At the end of the 29-month period, interest on the unpaid balance will be assessed at 4% per annum. Through December 31, 2020, our hospitals and other providers applied for and received approximately $1.5 billion of accelerated payments.

- A 6.2% increase in the Federal Medical Assistance Percentage ("FMAP") matching funds was instituted to help states respond to the COVID-19 pandemic. The additional funds are available to states from January 1, 2020 through the quarter in which the public health emergency period ends, provided that states meet certain conditions. An increase in states' FMAP leverages Medicaid's existing financing structure, which allows federal funds to be provided to states more quickly and efficiently than establishing a new program or allocating money from a new funding stream. Increased federal matching funds support states in responding to the increased need for services, such as testing and treatment during the COVID-19 public health emergency, as well as increased enrollment as more people lose income and qualify for Medicaid during the economic downturn.

Because of the uncertainty associated with various factors that may influence our future Medicare and Medicaid payments, including future legislative, legal or regulatory actions, or changes in volumes and case mix, there is a risk that our estimates of the impact of the aforementioned payment and policy changes will be incorrect and that actual payments received under, or the ultimate impact of, these programs will differ materially from our expectations.

Funding for Uninsured Individuals—The CARES Act provides claims reimbursement to healthcare providers generally at Medicare rates for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis. A portion of the funding will also be used to reimburse providers for COVID-19 vaccine administration to uninsured individuals.

Tax Changes—Beginning March 27, 2020, all employers were able to elect to defer payment of the 6.2% employer Social Security tax through December 31, 2020. Deferred tax amounts are required to be paid in equal amounts over two years, with payments due in December 2021 and December 2022. During the year ended December 31, 2020, we deferred Social Security tax payments totaling $275 million pursuant to this CARES Act provision. In addition, the CARES Act increases the interest expense deduction limitation from 30% of adjusted taxable income to 50% of adjusted taxable income for the 2019 and 2020 tax years, allowing businesses to take a larger deduction. This change is expected to increase our federal tax net operating loss ("NOL") carryforwards into future years, as further described in Note 19 to the accompanying Consolidated Financial Statements.

CMS Innovation Models

The CMS Innovation Center develops and tests innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid or CHIP expenditures while preserving or enhancing the quality of care for beneficiaries. Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations for CMS to conduct, including bundled payment models. Generally, the bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health care. Provider participation in some of these models is voluntary; for example, 34 hospitals in our Hospital Operations segment and six surgical hospitals in our Ambulatory Care segment participate in the CMS Bundled Payments for Care Improvement Advanced ("BPCIA") program that became effective October 1, 2018, and USPI also holds the CMS contract for two physician group practices participating in the BPCIA program. Participation in certain other bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. 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. Sixteen hospitals in our Hospital Operations segment and four surgical hospitals in our Ambulatory Care segment currently participate in the CJR model.

Significant Litigation

340B Litigation

The 340B program allows certain hospitals (i.e., only nonprofit organizations with specific federal designations and/or funding) ("340B Hospitals") to purchase drugs at discounted rates from drug manufacturers. In the final rule regarding Hospital OPPS payment and policy changes for CY 2018, CMS reduced the payment for 340B Drugs from ASP plus 6% to ASP minus 22.5% and made a corresponding budget-neutral increase to payments to all hospitals for other drugs and services reimbursed under the OPPS (the "340B Payment Adjustment"). In the final rules regarding OPPS payment and policy changes for CYs 2019, 2020 and 2021, CMS continued the 340B Payment Adjustment. Certain hospital associations and hospitals commenced litigation challenging CMS' authority to impose the 340B Payment Adjustment for CYs 2018, 2019 and 2020. In May 2019, the U.S. District Court for the District of Columbia (the "District Court") held that the adoption of the 340B Payment Adjustment in the CY 2019 OPPS Final Rule exceeded CMS' statutory authority by reducing drug reimbursement rates for 340B Hospitals. This holding followed the District Court's December 2018 conclusion that HHS exceeded its statutory authority in reducing the CY 2018 OPPS for the 340B Payment Adjustment. The District Court did not grant a permanent injunction to the 340B Payment Adjustment, nor did it vacate the 2018 and 2019 rules. In July 2019, the District Court issued a Memorandum Opinion granting HHS' motion for entry of final judgment, thus allowing HHS to proceed with a pending appeal of the District Court's rulings at the U.S. Court of Appeals for the District of Columbia Circuit (the "Circuit Court"). In July 2020, a three-judge panel of the Circuit Court reversed the District Court's holding, finding that HHS' decision to reduce the payment rate for 340B Drugs was based on a reasonable interpretation of the Medicare statute. In October 2020, the Circuit Court denied the plaintiff hospital associations' and hospitals' request for an en banc hearing. We cannot predict what further actions CMS or Congress might take with respect to the 340B program; however, the outcome could have an adverse effect on our net revenues and cash flows.

Medicare Disproportionate Share Hospital Litigation

Prior to October 1, 2013, DSH payments were based on the Pre-ACA DSH Formula. In the final rule regarding IPPS payment and policy changes for FFY 2005, CMS revised its policy on the calculation of one of the ratios used in the Pre-ACA DSH Formula. A group of hospitals challenged the policy change claiming that CMS failed to provide adequate notice and a comment period. The District Court vacated the rule. CMS appealed the ruling, and the Circuit Court affirmed the District Court's decision. Since then, CMS has continued to use the vacated policy and was again met with legal challenges. In 2019, the U.S. Supreme Court ("SCOTUS") upheld the Circuit Court's decision that CMS' continued use of the vacated policy is not legal. Although the SCOTUS decision applies only to the 2012 ratios for the plaintiff hospitals, it establishes a precedent that we believe will ultimately result in a favorable outcome in our pending Medicare DSH appeals for years 2005-2013; however, we cannot predict the timing or outcome of our appeals or when and how CMS will implement the SCOTUS decision. A favorable outcome of our DSH appeals could have a material impact on our future revenues and 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 service revenues, including Medicare and Medicaid managed care programs, from our hospitals and related outpatient facilities during the years ended December 31, 2020, 2019 and 2018 was $9.022 billion, $9.516 billion and $9.213 billion, respectively. Our top 10 managed care payers generated 62% of our managed care net patient service revenues for the year ended December 31, 2020. National payers generated 44% of our managed care net patient service revenues for the year ended December 31, 2020. The remainder comes from regional or local payers. At December 31, 2020 and 2019, 66% and 65%, respectively, of our net accounts receivable for our Hospital Operations segment were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted FFS rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at December 31, 2020, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $17 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage and payment levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. We believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for these payers and other factors that affect the estimation process.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefited from solid year-over-year aggregate managed care pricing improvements for some time, we have seen these improvements moderate in recent years, and we believe this moderation could continue into the future. In the year ended December 31, 2020, our commercial managed care net inpatient revenue per admission from the hospitals in our Hospital Operations segment was approximately 95% 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.

UNINSURED PATIENTS

Uninsured 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 uninsured 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 receivable, which include amounts due from uninsured patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance, pose significant collectability problems. At both December 31, 2020 and 2019, approximately 4% of our net accounts receivable for our Hospital Operations segment was self-pay. Further, a significant portion of our implicit price concessions relates to self-pay amounts. We provide revenue cycle management services through Conifer, which is subject to various statutes and regulations regarding consumer protection in

areas including finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of this report.

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

Over the longer term, several other initiatives we have previously announced should also help address the challenges associated with serving uninsured patients. 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. Under the *Compact*, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for self-pay accounts and other factors that affect the estimation process. We also provide financial assistance through our charity and uninsured discount programs to uninsured patients who are unable to pay for the healthcare services they receive. Our policy is not to pursue collection of amounts determined to qualify for financial assistance; 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. Some states have also developed provider fee or other supplemental payment programs to mitigate the shortfall of Medicaid reimbursement compared to the cost of caring for Medicaid patients.

The initial expansion of health insurance coverage resulted in an increase in the number of patients using our facilities with either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage and for persons living in the country who are not permitted to enroll in a health insurance exchange or government healthcare insurance program. The following table shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) of caring for our uninsured and charity patients in the years ended December 31, 2020, 2019 and 2018.

	Years Ended December 31,		
	2020	2019	2018
Estimated costs for:			
Uninsured patients	$ 617	$ 664	$ 641
Charity care patients	147	156	124
Total	$ 764	$ 820	$ 765

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2020 COMPARED TO THE YEAR ENDED DECEMBER 31, 2019

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, 2020 and 2019. We present metrics as a percentage of net operating revenues because a significant portion of our costs are variable.

	Years Ended December 31,		
	2020	2019	Increase (Decrease)
Net operating revenues:			
Hospital Operations	$ 14,790	$ 15,522	$ (732)
Ambulatory Care	2,072	2,158	(86)
Conifer	1,306	1,372	(66)
Inter-segment eliminations	(528)	(573)	45
Net operating revenues	**17,640**	**18,479**	**(839)**
Grant income	**882**	**—**	882
Equity in earnings of unconsolidated affiliates	**169**	**175**	**(6)**
Operating expenses:			
Salaries, wages and benefits	8,418	8,698	(280)
Supplies	2,982	3,057	(75)
Other operating expenses, net	4,125	4,171	(46)
Depreciation and amortization	857	850	7
Impairment and restructuring charges, and acquisition-related costs	290	185	105
Litigation and investigation costs	44	141	(97)
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(14)	15	(29)
Operating income	**$ 1,989**	**$ 1,537**	**$ 452**

	Years Ended December 31,		
	2020	2019	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Grant income	5.0 %	— %	5.0 %
Equity in earnings of unconsolidated affiliates	1.0 %	0.9 %	0.1 %
Operating expenses:			
Salaries, wages and benefits	47.8 %	47.0 %	0.8 %
Supplies	16.9 %	16.5 %	0.4 %
Other operating expenses, net	23.4 %	22.6 %	0.8 %
Depreciation and amortization	4.9 %	4.6 %	0.3 %
Impairment and restructuring charges, and acquisition-related costs	1.6 %	1.0 %	0.6 %
Litigation and investigation costs	0.2 %	0.8 %	(0.6) %
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(0.1) %	0.1 %	(0.2) %
Operating income	**11.3 %**	**8.3 %**	**3.0 %**

Total net operating revenues decreased by $839 million, or 4.5%, for the year ended December 31, 2020 compared to the year ended December 31, 2019. Hospital Operations net operating revenues, net of inter-segment eliminations, decreased by $687 million, or 4.6%, for the year ended December 31, 2020 compared to the same period in 2019, primarily due to lower patient volumes as a result of the COVID-19 pandemic, partially offset by higher patient acuity, a more favorable payer mix and improved terms of our managed care contracts.

Ambulatory Care net operating revenues decreased by $86 million, or 4.0%, for the year ended December 31, 2020 compared to the 2019 period. The decrease was primarily due to the negative impact of shelter-in-place orders on patient volumes and the mandated suspension of many elective procedures due to the COVID-19 pandemic, as well as a decrease of $40 million due to the deconsolidation of a facility. These impacts were partially offset by an increase from acquisitions of $105 million.

Conifer net operating revenues decreased by $66 million, or 4.8%, for the year ended December 31, 2020 compared to 2019. Conifer revenues from third-party customers, which are not eliminated in consolidation, decreased $21 million, or 2.6%, for the year ended December 31, 2020 compared to the 2019 period. Conifer's net operating revenues were negatively impacted

by the unfavorable downstream impact of the COVID-19 pandemic on its clients' patient volumes, as well as attrition due to planned hospital divestitures by its clients.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations segment is presented on a same-hospital basis, which includes the results of our same 65 hospitals operated throughout the years ended December 31, 2020 and 2019 and excludes the results of three Chicago-area hospitals we divested effective January 28, 2019. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented.

	Years Ended December 31,		
Selected Operating Expenses	**2020**	**2019**	**Increase (Decrease)**
Hospital Operations — Same-Hospital			
Salaries, wages and benefits	$ 7,136	$ 7,320	(2.5)%
Supplies	2,512	2,602	(3.5)%
Other operating expenses	3,512	3,560	(1.3)%
Total	$ 13,160	$ 13,482	(2.4)%
Ambulatory Care			
Salaries, wages and benefits	$ 609	$ 635	(4.1)%
Supplies	468	448	4.5 %
Other operating expenses	349	340	2.6 %
Total	$ 1,426	$ 1,423	0.2 %
Conifer			
Salaries, wages and benefits	$ 673	$ 727	(7.4)%
Supplies	3	4	(25.0)%
Other operating expenses	263	255	3.1 %
Total	$ 939	$ 986	(4.8)%
Total			
Salaries, wages and benefits	$ 8,418	$ 8,682	(3.0)%
Supplies	2,983	3,054	(2.3)%
Other operating expenses	4,124	4,155	(0.7)%
Total	$ 15,525	$ 15,891	(2.3)%
Rent/lease expense[1]			
Hospital Operations	$ 277	$ 240	15.4 %
Ambulatory Care	92	86	7.0 %
Conifer	12	11	9.1 %
Total	$ 381	$ 337	13.1 %

(1) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported in three segments:

- Hospital Operations, which is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. As described in Note 5 to the accompanying Consolidated Financial Statements, certain of these facilities were classified as held for sale at December 31, 2020 and 2019.

- Ambulatory Care, which is comprised of USPI's ASCs, urgent care centers, imaging centers and surgical hospitals. As described in Note 5 to the accompanying Consolidated Financial Statements, certain of these facilities were classified as held for sale at December 31, 2020. In December 2020, USPI acquired controlling interests in the SCD Centers, which added 45 ASCs to USPI's total centers.

- Conifer, which provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients.

Hospital Operations Segment

The following tables show operating statistics of our continuing operations hospitals and related outpatient facilities on a same-hospital basis, unless otherwise indicated, which includes the results of our same 65 hospitals operated throughout the years ended December 31, 2020 and 2019 and excludes the results of three Chicago-area hospitals we divested effective January 28, 2019. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented. We present certain metrics on a per-adjusted-patient-admission and per-adjusted-patient-day basis to show trends other than volume. We present certain metrics as a percentage of net operating revenues because a significant portion of our operating expenses are variable.

	Same-Hospital Continuing Operations			
	Years Ended December 31,			
Admissions, Patient Days and Surgeries	**2020**	**2019**	**Increase (Decrease)**	
Number of hospitals (at end of period)	65	65	—	(1)
Total admissions	604,017	683,641	(11.6)%	
Adjusted patient admissions(2)	1,030,872	1,222,856	(15.7)%	
Paying admissions (excludes charity and uninsured)	566,110	642,303	(11.9)%	
Charity and uninsured admissions	37,907	41,338	(8.3)%	
Admissions through emergency department	447,502	489,570	(8.6)%	
Paying admissions as a percentage of total admissions	93.7 %	94.0 %	(0.3)%	(1)
Charity and uninsured admissions as a percentage of total admissions	6.3 %	6.0 %	0.3 %	(1)
Emergency department admissions as a percentage of total admissions	74.1 %	71.6 %	2.5 %	(1)
Surgeries — inpatient	155,546	179,940	(13.6)%	
Surgeries — outpatient	203,123	240,221	(15.4)%	
Total surgeries	358,669	420,161	(14.6)%	
Patient days — total	3,072,897	3,181,793	(3.4)%	
Adjusted patient days(2)	5,104,639	5,572,035	(8.4)%	
Average length of stay (days)	5.09	4.65	9.5 %	
Licensed beds (at end of period)	17,178	17,210	(0.2)%	
Average licensed beds	17,221	17,215	— %	
Utilization of licensed beds(3)	48.8 %	50.6 %	(1.8)%	(1)

(1) The change is the difference between 2020 and 2019 amounts shown.

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations 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,			
Outpatient Visits	**2020**	**2019**	**Increase (Decrease)**	
Total visits	5,443,351	6,755,166	(19.4)%	
Paying visits (excludes charity and uninsured)	5,060,877	6,307,907	(19.8)%	
Charity and uninsured visits	382,474	447,259	(14.5)%	
Emergency department visits	1,959,335	2,561,805	(23.5)%	
Surgery visits	203,123	240,221	(15.4)%	
Paying visits as a percentage of total visits	93.0 %	93.4 %	(0.4)%	(1)
Charity and uninsured visits as a percentage of total visits	7.0 %	6.6 %	0.4 %	(1)

(1) The change is the difference between the 2020 and 2019 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2020	2019	Increase (Decrease)
Total segment net operating revenues(1)	$ 14,253	$ 14,918	(4.5) %
Selected revenue data – hospitals and related outpatient facilities			
Net patient service revenues(1)(2)	$ 13,611	$ 14,339	(5.1) %
Net patient service revenue per adjusted patient admission(1)(2)	$ 13,203	$ 11,726	12.6 %
Net patient service revenue per adjusted patient day(1)(2)	$ 2,666	$ 2,573	3.6 %

(1) Revenues are net of implicit price concessions.

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

Total Segment Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2020	2019	Increase (Decrease)	
Salaries, wages and benefits as a percentage of net operating revenues	50.1 %	49.1 %	1.0 %	(1)
Supplies as a percentage of net operating revenues	17.6 %	17.4 %	0.2 %	(1)
Other operating expenses as a percentage of net operating revenues	24.6 %	23.9 %	0.7 %	(1)

(1) The change is the difference between the 2020 and 2019 amounts shown.

Revenues

Same-hospital net operating revenues decreased $665 million, or 4.5%, during the year ended December 31, 2020 compared to the year ended December 31, 2019, primarily due to lower patient volumes as a result of the COVID-19 pandemic, partially offset by higher patient acuity, a more favorable payer mix and improved terms of our managed care contracts. Our Hospital Operations segment also recognized income from federal, state and local grants totaling $823 million during the year ended December 31, 2020, which is not included in net operating revenues. Same-hospital admissions decreased 11.6% in the year ended December 31, 2020 compared to the 2019 period. Same-hospital outpatient visits decreased 19.4% in the year ended December 31, 2020 compared to the 2019 period.

The following table shows the consolidated net accounts receivable by payer at December 31, 2020 and 2019:

	December 31, 2020	December 31, 2019
Medicare	$ 152	$ 189
Medicaid	49	69
Net cost report settlements receivable and valuation allowances	34	12
Managed care	1,567	1,618
Self-pay uninsured	32	25
Self-pay balance after insurance	74	76
Estimated future recoveries	156	162
Other payers	318	337
Total Hospital Operations	2,382	2,488
Ambulatory Care	307	253
Total discontinued operations	1	2
	$ 2,690	**$ 2,743**

When we have an unconditional right to payment, subject only to the passage of time, the right is treated as a receivable. Patient accounts receivable, including billed accounts and certain unbilled accounts, as well as estimated amounts due from third-party payers for retroactive adjustments, are receivables if our right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. Estimated uncollectable amounts are generally considered implicit price concessions that are a direct reduction to patient accounts receivable rather than allowance for doubtful accounts. Amounts related to services provided to patients for which we have not billed and that do not meet the conditions of unconditional right to payment at the end of the reporting period are contract assets. For our Hospital Operations segment, our contract assets include services that we have provided to patients who are still receiving inpatient care in our facilities at the end of the reporting period. Our Hospital Operations segment's contract assets are included in other current assets in the accompanying Consolidated Balance Sheets at December 31, 2020 and 2019.

Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2020, our Hospital Operations segment collection rate on self-pay accounts was approximately 25.5%. Our self-pay collection rate includes payments made by patients, including co-pays, co-insurance amounts and deductibles paid by patients with insurance. Based on our accounts receivable from uninsured patients and co-pays, co-insurance amounts and deductibles owed to us by patients with insurance at December 31, 2020, 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 patient accounts receivable of approximately $9 million. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors, many of which have been affected by the COVID-19 pandemic, continuously change and can have an impact on collection trends and our estimation process.

Payment pressure from managed care payers also affects the collectability of our accounts receivable. 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 segment collection rate from managed care payers was approximately 97.3% at December 31, 2020.

We manage our implicit price concessions using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) AR Days and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations segment of $2.348 billion and $2.476 billion at December 31, 2020 and 2019, respectively, excluding cost report settlements receivable and valuation allowances of $34 million and $12 million, respectively, at December 31, 2020 and 2019:

	December 31, 2020				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	91 %	33 %	58 %	24 %	52 %
61-120 days	5 %	31 %	15 %	13 %	14 %
121-180 days	2 %	14 %	8 %	8 %	8 %
Over 180 days	2 %	22 %	19 %	55 %	26 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

	December 31, 2019				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	91 %	49 %	56 %	21 %	51 %
61-120 days	5 %	21 %	16 %	14 %	15 %
121-180 days	2 %	10 %	10 %	10 %	9 %
Over 180 days	2 %	20 %	18 %	55 %	25 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

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 collections 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.

At December 31, 2020, we had a cumulative total of patient account assignments to Conifer of $2.264 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 Conifer 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 97% 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, 2020 and 2019 by aging category:

	December 31,	
	2020	2019
0-60 days	$ 91	$ 89
61-120 days	24	11
121-180 days	6	4
Over 180 days	6	11
Total	**$ 127**	**$ 115**

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits decreased by $184 million, or 2.5%, in the year ended December 31, 2020 compared to the year ended December 31, 2019. This decrease is primarily attributable to reduced patient volumes as a result of the COVID-19 pandemic, decreased health benefits costs, and the impact of previously announced workforce reductions as part of our enterprise-wide cost-reduction and efficiency initiatives. The decrease was partially offset by higher costs due to an increased average length of patient stay, annual merit increases for certain of our employees, a greater number of employed physicians and increased incentive compensation expense. Same-hospital salaries, wages and benefits as a percentage of net operating revenues increased by 100 basis points to 50.1% in the year ended December 31, 2020 compared to the 2019 period. This increase is primarily due to reduced patient revenues as a result of the COVID-19 pandemic. Salaries, wages and benefits expense for the years ended December 31, 2020 and 2019 included stock-based compensation expense of $28 million and $30 million, respectively.

Supplies

Same-hospital supplies expense decreased by $90 million, or 3.5%, in the year ended December 31, 2020 compared to the same period in 2019. This decrease was primarily attributable to reduced patient volumes as a result of the COVID-19 pandemic, as well as the impact of the group-purchasing strategies and supplies-management services we utilize to reduce costs. The decrease was partially offset by increased costs of certain supplies as a result of the COVID-19 pandemic, as well as growth in our higher-acuity, supply-intensive surgical services. Same-hospital supplies expense as a percentage of net operating revenues increased by 20 basis points to 17.6% in the year ended December 31, 2020 compared to the 2019 period. This increase is due to reduced patient revenues as a result of the COVID-19 pandemic.

We strive to control supplies expense through product standardization, consistent contract terms and end-to-end contract management, improved utilization, bulk purchases, focused spending with a smaller number of vendors and operational improvements. The items of current cost-reduction focus include personal protective equipment, cardiac stents and pacemakers, orthopedics, implants and high-cost pharmaceuticals.

Other Operating Expenses, Net

Same-hospital other operating expenses decreased by $48 million, or 1.3%, in the year ended December 31, 2020 compared to the same period in 2019. Same-hospital other operating expenses as a percentage of net operating revenues increased by 70 basis points to 24.6% compared to 23.9% in the year ended December 31, 2019, primarily due to reduced patient revenues as a result of the COVID-19 pandemic. Additionally, there is proportionally a higher level of fixed costs (e.g., rent expense) in other operating expenses than salaries, wages and benefits or supplies expense. The changes in other operating expenses included:

- increased medical fees of $103 million;
- increased rent and lease expense of $39 million;
- decreased consulting and legal fees of $36 million;

- decreased costs of contracted services of $17 million;
- decreased expenses related to our risk-contracting business in California of $17 million;
- decreased repair and maintenance costs of $17 million;
- decreased malpractice expense of $33 million;
- decreased costs of $40 million associated with funding indigent care services at our hospitals, which costs were substantially offset by reduced net patient revenues; and
- increased gains on asset sales of $18 million compared to the 2019 period primarily related to the divestiture of a medical office building.

Ambulatory Care Segment

Our Ambulatory Care segment is comprised of USPI's ASCs, urgent care centers, imaging centers and surgical hospitals. USPI operates its surgical facilities in partnership with local physicians and, in many of these facilities, a health system partner. We hold an ownership interest in each facility, with each being operated through a separate legal entity in most cases. USPI 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 implicit price concessions); 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 USPI.

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. For many of the facilities our Ambulatory Care segment operates (106 of 396 facilities at December 31, 2020), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method for an unconsolidated affiliate. USPI controls 290 of the facilities our Ambulatory Care segment operates, and we account for these investments as consolidated subsidiaries. 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 USPI is classified within "net income available 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 (loss) of each facility, which is based on the facility's net income (loss) and the percentage of the facility's outstanding equity interests owned by USPI; 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 implicit price concessions.

Our Ambulatory Care segment operating income is driven by the performance of all facilities USPI operates and by USPI's ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 73% of those facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses, which is why we disclose certain statistical and financial data on a pro forma systemwide basis that includes both consolidated and unconsolidated (equity method) facilities.

Year Ended December 31, 2020 Compared to the Year Ended December 31, 2019

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

	Years Ended December 31,		
Ambulatory Care Results of Operations	**2020**	**2019**	**Increase (Decrease)**
Net operating revenues	$ 2,072	$ 2,158	(4.0) %
Grant income	$ 59	$ —	N/A
Equity in earnings of unconsolidated affiliates	$ 163	$ 160	1.9 %
Salaries, wages and benefits	$ 609	$ 635	(4.1) %
Supplies	$ 468	$ 448	4.5 %
Other operating expenses, net	$ 349	$ 340	2.6 %

Our Ambulatory Care net operating revenues decreased by $86 million, or 4.0%, for the year ended December 31, 2020 compared to the 2019 period. The change was driven by a decrease in same-facility net operating revenues of $151 million due primarily to the COVID-19 pandemic, as well as a decrease of $40 million due to the deconsolidation of a facility, partially offset by an increase from acquisitions of $105 million. Our Ambulatory Care segment also recognized income from federal grants totaling $59 million during the year ended December 31, 2020, which is not included in net operating revenues.

Salaries, wages and benefits expense decreased by $26 million, or 4.1%, during the year ended December 31, 2020 compared to the same period in 2019. This change is attributable to a decrease in same-facility salaries, wages and benefits expense of $41 million due primarily to the necessary flexing of staff as patient volumes decreased at our centers early in the year due to shelter-in-place orders and the mandated suspension of many elective procedures at the beginning of the COVID-19 pandemic, as well as a decrease of $9 million due to the deconsolidation of a facility. These impacts were partially offset by an increase from acquisitions of $24 million. Salaries, wages and benefits expense for the years ended December 31, 2020 and 2019 included stock-based compensation expense of $14 million and $11 million, respectively.

Supplies expense increased by $20 million, or 4.5%, during the year ended December 31, 2020 compared to 2019. The change was driven by an increase from acquisitions of $33 million, partially offset by a decrease in same-facility supplies expense of $1 million as a result of the reduced number of cases due to the COVID-19 pandemic, as well as a decrease of $12 million due to the deconsolidation of a facility.

Other operating expenses increased by $9 million, or 2.6%, during the year ended December 31, 2020 compared to the 2019 period. The change was driven by an increase from acquisitions of $18 million, partially offset by a decrease in same-facility other operating expenses of $2 million due primarily to strong expense management while patient volumes were reduced as a result of the COVID-19 pandemic, as well as a decrease of $7 million due to the deconsolidation of a facility.

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, 2020**
Net revenues	(5.6)%
Cases	(10.0)%
Net revenue per case	4.9%

Joint Ventures with Health System Partners

USPI's business model is to jointly own its facilities with local physicians and, in many of these facilities, a not-for-profit health system partner. Accordingly, as of December 31, 2020, the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities	Year Ended December 31, 2020
Facilities:	
With a health system partner	222
Without a health system partner	174
Total facilities operated	396
Change from December 31, 2019:	
Acquisitions	55
De novo	3
Dispositions/Mergers	(8)
Total increase in number of facilities operated	50

During the year ended December 31, 2020, we acquired controlling interests in 52 ASCs in Arizona, Colorado, Florida, Indiana, Louisiana, Maryland, Missouri, New Hampshire, Ohio, Tennessee, Texas, Washington and Wisconsin, 45 of which were acquired in December 2020, as well as one imaging center in Texas. We paid cash totaling approximately $1.2 billion for these acquisitions. Of these 53 newly acquired outpatient centers, one is jointly owned with a health system partner, four are jointly owned with a health system partner and local physicians, and 48 are jointly owned with local physicians only. We also opened two new ASCs and one urgent care center, closed two ASCs and deconsolidated one ASC during the year ended December 31, 2020.

During the year ended December 31, 2020, we acquired noncontrolling interests in one surgical hospital and one ASC, both of which are located in California. We paid cash totaling approximately $24 million for these ownership interests. Each of these facilities is jointly owned with local physicians and health system partners.

We also regularly engage in the purchase of equity interests with respect to our investments in unconsolidated affiliates and consolidated facilities that do not result in a change of control. These transactions are primarily the acquisitions of equity interests in ASCs and the investment of additional cash in facilities that need capital for acquisitions, new construction or other business growth opportunities. During the year ended December 31, 2020, we invested approximately $1 million in such transactions.

Conifer Segment

Our Conifer segment generated net operating revenues of $1.306 billion and $1.372 billion during the years ended December 31, 2020 and 2019, respectively, a portion of which was eliminated in consolidation as described in Note 23 to the accompanying Consolidated Financial Statements. Conifer revenues from third-party customers, which are not eliminated in consolidation, decreased $21 million, or 2.6%, for the year ended December 31, 2020 compared to the 2019 period. Conifer's net operating revenues were negatively impacted by the unfavorable downstream impact of the COVID-19 pandemic on its clients' patient volumes, as well as attrition due to planned hospital divestitures by its clients.

Salaries, wages and benefits expense for Conifer decreased $54 million, or 7.4%, in the year ended December 31, 2020 compared to the year ended December 31, 2019 primarily due to cost savings realized through our Global Business Center. Salaries, wages and benefits expense for the years ended December 31, 2020 and 2019 included stock-based compensation expense of $2 million and $1 million, respectively.

Other operating expenses for Conifer increased $8 million, or 3.1%, in the year ended December 31, 2020 compared to the year ended December 31, 2019.

Agreements document the current terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations segment provides to Conifer; however, execution of a restructured long-term services agreement between Conifer and Tenet is a condition to completion of the proposed spin-off. Conifer's contract with Tenet represented 40.4% of the net operating revenues Conifer recognized in the year ended December 31, 2020.

Consolidated

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the year ended December 31, 2020, we recorded impairment and restructuring charges and acquisition-related costs of $290 million, consisting of $92 million of impairment charges, $184 million of restructuring charges and $14 million of acquisition-related costs. Impairment charges included $76 million for the write-down of hospital buildings to their estimated fair values in one of our markets, which assets are part of our Hospital Operations segment. Material adverse trends in our recent estimates of future undiscounted cash flows of the hospitals indicated the aggregate 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 included 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 it to the aggregate carrying value of those assets. Because the fair value estimates were lower than the aggregate carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of the hospitals' assets held and used for which impairment charges were recorded was $483 million at December 31, 2020. We also recorded $16 million of other impairment charges. Restructuring charges consisted of $65 million of employee severance costs, $50 million related to the transitioning of various administrative functions to our Global Business Center, $23 million of charges due to the termination of the USPI management equity plan, $14 million of contract and lease termination fees, and $32 million of other restructuring costs. Acquisition-related costs consisted of $14 million of transaction costs. Our impairment and restructuring charges and acquisition-related costs for the year ended December 31, 2020 were comprised of $187 million from our Hospital Operations segment, $57 million from our Ambulatory Care segment and $46 million from our Conifer segment.

During the year ended December 31, 2019, we recorded impairment and restructuring charges and acquisition-related costs of $185 million, consisting of $42 million of impairment charges, $137 million of restructuring charges and $6 million of acquisition-related costs. Impairment charges consisted of $26 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Memphis-area facilities and $16 million of other impairment charges. Restructuring charges consisted of $57 million of employee severance costs, $28 million related to the transitioning of various administrative functions to our Global Business Center, $6 million of contract and lease termination fees, and $46 million of other restructuring costs. Acquisition-related costs consisted of $6 million of transaction costs. Our impairment and restructuring charges and acquisition-related costs for the year ended December 31, 2019 were comprised of $111 million from our Hospital Operations segment, $18 million from our Ambulatory Care segment and $56 million from our Conifer segment.

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, which could be material.

Litigation and Investigation Costs

Litigation and investigation costs for the years ended December 31, 2020 and 2019 were $44 million and $141 million, respectively, primarily related to costs associated with significant legal proceedings and governmental investigations. The costs in the 2019 period include accruals for a now-resolved matter described in Note 17 to the accompanying Consolidated Financial Statements.

Net Gains (Losses) on Sales, Consolidation and Deconsolidation of Facilities

During the year ended December 31, 2020, we recorded net gains on sales, consolidation and deconsolidation of facilities of $14 million, primarily comprised of aggregate gains of $15 million related to consolidation changes of certain USPI businesses due to ownership changes and a gain of $7 million related to post-closing adjustments on the 2017 sale of facilities in the Houston area, partially offset by a loss of $5 million related to post-closing adjustments on the 2019 sale of three of our hospitals in the Chicago area and a loss of $3 million related to post-closing adjustments on the 2018 sale of MacNeal Hospital.

During the year ended December 31, 2019, we recorded net losses on sales, consolidation and deconsolidation of facilities of $15 million, primarily comprised of a $14 million loss on the sale of three of our hospitals in the Chicago area, as well as other operations affiliated with the hospitals.

Interest Expense

Interest expense for the year ended December 31, 2020 was $1.003 billion compared to $985 million for the year ended December 31, 2019.

Loss from Early Extinguishment of Debt

Loss from early extinguishment of debt was $316 million for the year ended December 31, 2020. This loss consisted of aggregate losses of $320 million related to the debt redemption and purchase transactions described in Note 8 to the accompanying Consolidated Financial Statements, partially offset by $4 million of gains on the extinguishment of mortgage notes.

Loss from early extinguishment of debt was $227 million for the year ended December 31, 2019, consisting of losses related to the debt redemption transactions described in Note 8 to the accompanying Consolidated Financial Statements.

Income Tax Expense

During the year ended December 31, 2020, we recorded an income tax benefit of $97 million in continuing operations on pre-tax income of $671 million compared to income tax expense of $160 million in continuing operations on pre-tax income of $320 million during the year ended December 31, 2019. The reconciliation between the amount of recorded income tax expense (benefit) and the amount calculated at the statutory federal tax rate is shown in the following table:

	Years Ended December 31,	
	2020	**2019**
Tax expense at statutory federal rate of 21%	$ 141	$ 67
State income taxes, net of federal income tax benefit	33	21
Expired state net operating losses, net of federal income tax benefit	1	2
Tax attributable to noncontrolling interests	(75)	(79)
Nondeductible goodwill	—	4
Nondeductible executive compensation	6	6
Nondeductible litigation costs	—	7
Expired charitable contribution carryforward	1	8
Stock-based compensation tax deficiencies (benefits)	(2)	4
Changes in valuation allowance	(226)	133
Change in tax contingency reserves, including interest	—	(14)
Prior-year provision to return adjustments and other changes in deferred taxes	14	(3)
Other items	10	4
Income tax expense (benefit)	**$ (97)**	**$ 160**

As a result of the change in the business interest expense disallowance rules under the CARES Act, we recorded an income tax benefit of $88 million during the year ended December 31, 2020 to decrease the valuation allowance for interest expense and carryforwards due to the additional deduction of interest expense. In September 2020, we filed an application with the Internal Revenue Services (“IRS”) to change our method of accounting for certain capitalized costs on our 2019 tax return. This change in tax accounting method resulted in additional interest expense being allowed on our 2019 and 2020 tax returns. We reduced our valuation allowance by an additional $126 million in the year ended December 31, 2020 related to the change in tax accounting method. Charitable contribution carryforward and state valuation allowance changes resulted in an additional $12 million decrease for the year ended December 31, 2020.

Net Income Available to Noncontrolling Interests

Net income available to noncontrolling interests was $369 million for the year ended December 31, 2020 compared to $386 million for the year ended December 31, 2019. Net income available to noncontrolling interests in the 2020 period was comprised of $322 million of income related to our Ambulatory Care segment and $66 million of income related to our Conifer segment, partially offset by a $19 million loss related to our Hospital Operations segment. Of the portion related to our Ambulatory Care segment, $12 million of income was related to the minority interests in USPI.

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, we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure we define 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 attributable (income available) to noncontrolling interests, (3) income (loss) from discontinued operations, net of tax (4) income tax benefit (expense), (5) gain (loss) from early extinguishment of debt, (6) other non-operating income (expense), net, (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, (11) depreciation and amortization, and (12) income (loss) from divested and closed businesses (i.e., our health plan businesses). Litigation and investigation costs do not include ordinary course of business malpractice and other litigation and related expense.

We believe the foregoing non-GAAP measure is useful to investors and analysts because it presents additional information about our financial performance. Investors, analysts, company management and our board of directors utilize this non-GAAP measure, in addition to GAAP measures, to track our financial and operating performance and compare that performance to peer companies, which utilize similar non-GAAP measures in their presentations. The human resources committee of our board of directors also uses certain non-GAAP measures to evaluate management's performance for the purpose of determining incentive compensation. We believe that Adjusted EBITDA is a useful measure, in part, because certain investors and analysts use both historical and projected Adjusted EBITDA, in addition to GAAP and other non-GAAP measures, as factors in determining the estimated fair value of shares of our common stock. Company management also regularly reviews the Adjusted EBITDA performance for each operating segment. We do not use Adjusted EBITDA to measure liquidity, but instead to measure operating performance. The non-GAAP Adjusted EBITDA measure we utilize 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 our financial performance.

The following table 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, 2020 and 2019:

	Years Ended December 31,	
	2020	2019
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 399**	**$ (215)**
Less: Net income available to noncontrolling interests	(369)	(386)
Income from discontinued operations, net of tax	—	11
Income from continuing operations	768	160
Income tax benefit (expense)	97	(160)
Loss from early extinguishment of debt	(316)	(227)
Other non-operating income (expense), net	1	(5)
Interest expense	(1,003)	(985)
Operating income	1,989	1,537
Litigation and investigation costs	(44)	(141)
Net gains (losses) on sales, consolidation and deconsolidation of facilities	14	(15)
Impairment and restructuring charges, and acquisition-related costs	(290)	(185)
Depreciation and amortization	(857)	(850)
Income (loss) from divested and closed businesses	20	(2)
Adjusted EBITDA	**$ 3,146**	**$ 2,730**
Net operating revenues	**$ 17,640**	**$ 18,479**
Less: Net operating revenues from health plans	**21**	**1**
Adjusted net operating revenues	**$ 17,619**	**$ 18,478**
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders as a % of net operating revenues	**2.3 %**	**(1.2)%**
Adjusted EBITDA as % of adjusted net operating revenues (Adjusted EBITDA margin)	**17.9 %**	**14.8 %**

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2019 COMPARED TO THE YEAR ENDED DECEMBER 31, 2018

A discussion of the results of operations for the year ended December 31, 2019 compared to the year ended December 31, 2018 prior to the recast to reflect retrospective application of a change in accounting principle can be found in our Annual Report on Form 10-K for the year ended December 31, 2019. The impact of the recast on our results for prior periods is described in Note 1 to the accompanying Consolidated Financial Statements.

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Our obligations to make future cash payments under contracts, such as debt and lease agreements, and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, are summarized in the table below, all as of December 31, 2020:

		Years Ended December 31,					
	Total	2021	2022	2023	2024	2025	Later Years
				(In Millions)			
Long-term debt[1]	$ 20,557	$ 910	$ 916	$ 2,717	$ 3,239	$ 3,177	$ 9,598
Finance lease obligations[1]	342	133	73	29	11	9	87
Long-term non-cancelable operating leases[1]	1,487	231	212	191	168	141	544
Medicare accelerated payment program[2]	1,505	603	902	—	—	—	—
Standby letters of credit	88	88	—	—	—	—	—
Guarantees[3]	222	116	42	11	8	7	38
Asset retirement obligations	166	—	—	—	—	—	166
Academic affiliation agreements[4]	82	43	33	6	—	—	—
Tax liabilities	5	—	—	—	—	—	5
Defined benefit plan obligations	544	63	23	23	23	23	389
Information technology contract services	788	242	214	203	119	2	8
Purchase orders	318	318	—	—	—	—	—
Total[4]	**$ 26,104**	**$ 2,747**	**$ 2,415**	**$ 3,180**	**$ 3,568**	**$ 3,359**	**$ 10,835**

(1) Includes interest through maturity date/lease termination.
(2) Includes $113 million of Medicare accelerated payments received by our unconsolidated affiliates for whom we provide cash management services.
(3) Includes minimum revenue guarantees, primarily related to physicians under relocation agreements and physician groups that provide services at our hospitals, and operating lease guarantees.
(4) These agreements contain various rights and termination provisions.
(5) Professional liability and workers' compensation reserves, and our obligations under the Baylor Put/Call Agreement, as defined and described in Note 18 to our Consolidated Financial Statements, have been excluded from the table. At December 31, 2020, the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were $243 million and $735 million, respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were $40 million and $117 million, respectively. Redeemable noncontrolling interests in USPI that are subject to the Baylor Put/Call Agreement totaled $226 million at December 31, 2020.

Standby letters of credit are required principally by our insurers and various states to collateralize our workers' compensation programs pursuant to statutory requirements and as security to collateralize the deductible and self-insured retentions under certain of our professional and general liability insurance programs. The amount of collateral required is primarily dependent upon the level of claims activity and our creditworthiness. The insurers require the collateral in case we are unable to meet our obligations to claimants within the deductible or self-insured retention layers.

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2020:

- On September 16, 2020, we sold $2.500 billion aggregate principal amount of6.125% senior notes, which will mature on October 1, 2028 (the "2028 Senior Notes"). We will pay interest on the 2028 Senior Notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2021. The proceeds from the sale of the 2028 Senior Notes were used, after payment of fees and expenses, together with cash on hand, to finance the redemption of all $2.556 billion aggregate principal amount then outstanding of our 8.125% senior unsecured notes due 2022 (the "2022 Senior Notes") for approximately $2.843 billion. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $305 million in the three months ended September 30, 2020, primarily related to the difference between the purchase price and the par value of the 2022 Senior Notes, as well as the write-off of associated unamortized issuance costs.

- In August and July 2020, we purchased approximately $109 million aggregate principal amount of our 2022 Senior Notes for approximately $114 million. In connection with the purchases, we recorded losses from early extinguishment of debt totaling $7 million in the three months ended September 30, 2020, primarily related to the differences between the purchase prices and the par values of the 2022 Senior Notes, as well as the write-offs of associated unamortized issuance costs.

- In June 2020, we purchased approximately $135 million aggregate principal amount of our 2022 Senior Notes for approximately $142 million. In connection with the purchase, we recorded a loss from early extinguishment of debt of approximately $8 million in the three months ended June 30, 2020, primarily related to the difference between the purchase price and the par value of the 2022 Senior Notes, as well as the write-off of associated unamortized issuance costs.

- On June 16, 2020, we sold $600 million aggregate principal amount of 4.625% senior secured first lien notes, which will mature on June 15, 2028 (the "2028 Senior Secured First Lien Notes"). We will pay interest on the 2028 Senior Secured First Lien Notes semi-annually in arrears on June 15 and December 15 of each year, which payments commenced on December 15, 2020.

- On April 7, 2020, we sold $700 million aggregate principal amount of 7.500% senior secured first lien notes, which will mature on April 1, 2025 (the "2025 Senior Secured First Lien Notes"). We will pay interest on the 2025 Senior Secured First Lien Notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2020. A portion of the proceeds from the sale of the 2025 Senior Secured First Lien Notes was used, after payment of fees and expenses, to repay the $500 million aggregate principal amount of borrowings outstanding under our Credit Agreement as of March 31, 2020.

At December 31, 2020, using the last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 4.22x. This ratio at December 31, 2020 was temporarily impacted by the increase in cash received from advances from Medicare. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including the use of our revolving credit facility as a source of liquidity and acquisitions that involve the assumption of long-term debt. We seek to manage this ratio and increase the efficiency of our balance sheet by following our business plan and managing our cost structure, including through possible asset divestitures, and through other changes in our capital structure. As part of our long-term objective to manage our capital structure, we may seek to retire, purchase, redeem or refinance some of our outstanding debt or issue equity or convertible securities, in each case subject to prevailing market conditions, our liquidity requirements, operating results, contractual restrictions and other factors. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections in Part I of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements, introduction of new medical technologies, design and construction of new buildings, and various other capital improvements, as well as commitments to make capital expenditures in connection with acquisitions of businesses. Capital expenditures were $540 million, $670 million and $617 million in the years ended December 31, 2020, 2019 and 2018, respectively. We had initially anticipated higher capital expenditures in 2020 than we had in 2019, but we later decided to reduce planned 2020 capital expenditures in response to the COVID-19 pandemic. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2021 will total approximately $700 million to $750 million, including $93 million that was accrued as a liability at December 31, 2020. We have initiated construction on a new 100-bed acute care hospital in Fort Mill, South Carolina. The general contractor mobilized in December 2020, completing all pre-construction conditions of the certificate of need approval. Our plans have been submitted to and approved by the South Carolina Department of Health and Environment Control. The project is currently on schedule for completion in the third quarter of 2022, and we expect it to cost approximately $150 million over the construction period.

Interest payments, net of capitalized interest, were $962 million, $946 million and $976 million in the years ended December 31, 2020, 2019 and 2018, respectively. For the year ending December 31, 2021, we expect annual interest payments to be approximately $920 million to $930 million.

Income tax payments, net of tax refunds, were $12 million in both of the years ended December 31, 2020 and 2019 and $25 million in the year ended December 31, 2018. At December 31, 2020, our carryforwards available to offset future taxable income consisted of (1) federal NOL carryforwards of approximately $2.367 billion pre-tax, $1.126 billion of which expires in 2021 to 2034 and $1.241 billion of which has no expiration date, (2) general business credit carryforwards of approximately $25 million expiring in 2023 through 2039, (3) charitable contribution carryforwards of approximately $195 million expiring in 2021 through 2025 and (4) state NOL carryforwards of $3.728 billion expiring in 2021 through 2040 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $61 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs, the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such

ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

Periodic examinations of our tax returns by the IRS or other taxing authorities could result in the payment of additional taxes. The IRS has completed audits of our tax returns for all tax years ended on or before December 31, 2007. All disputed issues with respect to these audits have been resolved and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007 and USPI's tax returns for years ended after December 31, 2016 remain subject to audit by the IRS.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2020 was primarily derived from net cash provided by operating activities, cash on hand and borrowings under our revolving credit facility. During 2020, we also received supplemental funds from Medicare and from federal, state and local grants pursuant to legislation designed to mitigate the disruptive effects of the COVID-19 pandemic. We had $2.446 billion of cash and cash equivalents on hand at December 31, 2020 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $1.900 billion based on our borrowing base calculation at December 31, 2020.

When operating under normal conditions, our primary source of operating cash is the collection of accounts receivable. As such, our operating cash flow is impacted by levels of cash collections, as well as levels of implicit price concessions, due to shifts in payer mix and other factors.

Net cash provided by operating activities was $3.407 billion for the year ended December 31, 2020 compared to $1.233 billion for the year ended December 31, 2019. Key factors contributing to the change between the 2020 and 2019 periods include the following:

- Approximately $1.4 billion of cash advances received from Medicare pursuant to COVID-19 stimulus legislation;
- $900 million of cash received from federal, state and local grants, including the Provider Relief Fund;
- A $260 million deferral of our payroll tax match in 2020 pursuant to COVID-19 stimulus legislation;
- Decreased cash receipts of $81 million related to supplemental Medicaid programs in California and Texas;
- Higher interest payments of $16 million in the 2020 period;
- An increase of $141 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- The timing of other working capital items.

Net cash used in investing activities was $1.608 billion for the year ended December 31, 2020 compared to $619 million for the year ended December 31, 2019. The 2020 amount included an increase in investments for purchases of businesses or joint venture interests of $1.152 billion, primarily due to the acquisition of controlling interests in 45 ASCs in December 2020. The 2019 period included proceeds from sales of facilities and other assets of $63 million primarily from the sale of three hospitals and hospital-affiliated operations in the Chicago area. Additionally, capital expenditures decreased from $670 million in 2019 to $540 million in 2020, reflecting our decision to reduce planned capital expenditures in response to the COVID-19 pandemic.

Net cash provided by financing activities was $385 million for the year ended December 31, 2020 compared to net cash used in financing activities of $763 million for the year ended December 31, 2019. The 2020 amount included proceeds from the issuance of $2.5 billion aggregate principal amount of our 2028 Senior Notes, $700 million aggregate principal amount of our 2025 Senior Secured First Lien Notes and $600 million aggregate principal amount of our 2028 Senior Secured First Lien Notes. The 2020 amount also included $3.1 billion of payments for our redemption and purchase of $2.8 billion aggregate principal amount of our outstanding 2022 Senior Notes, $113 million of cash advances from Medicare and $74 million of stimulus grants received by our Ambulatory Care segment's non-consolidated affiliates. In 2019, we sold a total of $5.7 billion aggregate principal amount of notes. The proceeds from the sales of those notes were used, after payment of fees and expenses, together with cash on hand and borrowings under our senior secured revolving credit facility, to fund the

redemptions of a total of $5.7 billion aggregate principal amount of notes. The 2019 amount also included $70 million of cash paid for debt issuance costs related to these transactions. For additional information regarding our long-term debt, see Note 8 to the accompanying Consolidated Financial Statements.

We have several structured payables arrangements that are a part of our strategy to make our procurement processes more efficient and cost effective. At December 31, 2020, we were paying approximately 3,750 vendors under these programs, with an annual charge volume of approximately $844 million. We do not expect these programs to result in any significant changes to our liquidity.

We record our equity securities and our debt securities classified as available-for-sale at fair market value. The majority of our investments are valued based on quoted market prices or other observable inputs. We have no investments that we expect will be negatively affected by the current economic conditions such that they will materially impact our financial condition, results of operations or cash flows.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

Credit Agreement. We amended the credit agreement for our senior secured revolving credit facility in April 2020 (as amended, the "Credit Agreement") to, among other things, (i) increase the aggregate revolving credit commitments from the previous limit of $1.5 billion to $1.9 billion, subject to borrowing availability, and (ii) increase the advance rate and raise limits on certain eligible accounts receivable in the calculation of the borrowing base, in each case, for an incremental period of 364 days. In addition to revolving loans, our senior secured revolving credit facility provides a $200 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of September 12, 2024, are guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and are secured by a first-priority lien on the eligible inventory and accounts receivable owned by us and the subsidiary guarantors, including receivables for Medicaid supplemental payments. At December 31, 2020, we were in compliance with all covenants and conditions in our Credit Agreement. At December 31, 2020, we had no cash borrowings outstanding under the Credit Agreement, and we had less than $1 million of standby letters of credit outstanding. Based on our eligible receivables, $1.9 billion was available for borrowing under the Credit Agreement at December 31, 2020.

Letter of Credit Facility. In March 2020, we amended our letter of credit facility (as amended, the "LC Facility") to extend the scheduled maturity date of the LC Facility from March 7, 2021 to September 12, 2024 and to increase the aggregate principal amount of standby and documentary letters of credit that from time to time may be issued thereunder from $180 million to $200 million. In July 2020, we further amended the LC Facility to increase the maximum secured debt covenant from 4.00 to 1.00 on a quarterly basis up to 6.00 to 1.00 for the quarter ending March 31, 2021, which maximum ratio will step down on a quarterly basis through the quarter ending December 31, 2021. Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes. At December 31, 2020, we were in compliance with all covenants and conditions in our LC Facility. At December 31, 2020, we had $88 million of standby letters of credit outstanding under the LC Facility.

Senior Secured and Senior Unsecured Note Refinancing Transactions. In 2020, we sold $2.5 billion aggregate principal amount of our 2028 Senior Notes, $700 million aggregate principal amount of our 2025 Senior Secured First Lien Notes and $600 million aggregate principal amount of our 2028 Senior Secured First Lien Notes. The proceeds from the sales of these notes were used, after payment of fees and expenses, together with cash on hand, to fund the redemptions of a total $3.1 billion of payments for our redemption and purchase of $2.8 billion aggregate principal amount of our outstanding 2022 Senior Notes and to repay outstanding borrowings under the Credit Agreement.

LIQUIDITY

Broad economic factors resulting from the COVID-19 pandemic, including increased unemployment rates and reduced consumer spending, are impacting our service mix, revenue mix and patient volumes. Business closings and layoffs in the areas we operate may lead to increases in the uninsured and underinsured populations and adversely affect demand for our services, as well as the ability of patients to pay for services as rendered. Any increase in the amount of or deterioration in the collectability of patient accounts receivable could adversely affect our cash flows and results of operations. If general economic conditions continue to deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be impacted.

While demand for our services is expected to further rebound in the future, we have taken, and continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues

from the pandemic. In 2020, we sold $2.500 billion aggregate principal amount of our 2028 Senior Notes, $700 million aggregate principal amount of our 2025 Senior Secured First Lien Notes and $600 million aggregate principal amount of our 2028 Senior Secured First Lien Notes. The net proceeds from these issuances was used to redeem and purchase $2.8 billion aggregate principal amount of our outstanding 2022 Senior Notes and to repay borrowings outstanding under our Credit Agreement.

In addition, we amended our Credit Agreement in April 2020 to increase our borrowing availability and make certain changes with respect to the calculation of our borrowing base. We also reduced our planned capital expenditures for 2020 by approximately 25%. Furthermore, we decreased our employee headcount throughout the organization, and we deferred certain operating expenses that were not expected to impact our response to the COVID-19 pandemic. In addition, we reduced certain variable costs across the enterprise. We believe these actions, together with government relief packages, to the extent available to us, will help us to continue operating during the uncertainty caused by the COVID-19 pandemic. As more fully described under "Sources of Revenue for Our Hospital Operations Segment – Government Programs" above:

- The Medicare FFS accelerated and advanced payment program has been expanded. Through December 31, 2020, our hospitals and other providers applied for and received approximately $1.5 billion of accelerated payments. We expect to repay these advances within the allocated recoupment period.

- Beginning March 27, 2020, all employers were permitted to defer payment of the 6.2% employer Social Security tax through December 31, 2020. Deferred tax amounts are required to be paid in equal amounts over two years, with payments due in December 2021 and December 2022. During the year ended December 31, 2020, we deferred Social Security tax payments totaling $275 million pursuant to this CARES Act provision.

- To address the fiscal burdens on healthcare providers created by the COVID-19 public health emergency, the CARES Act and the PPP Act authorized $178 billion for the Provider Relief Fund. In the year ended December 31, 2020, we received cash payments of $974 million due to federal, state and local grants, including the PRF. Payments from the PRF are not loans and, therefore, they are not subject to repayment. However, as a condition to receiving distributions, providers must agree to certain terms and conditions, including, among other things, that the funds are being used for lost revenues and unreimbursed COVID-related costs as defined by HHS, and that the providers will not seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. As previously noted, HHS guidance related to grant funds is still evolving and subject to change.

- Effective May 1, 2020 through March 31, 2021, the 2% sequestration reduction on Medicare FFS and Medicare Advantage payments to hospitals, physicians and other providers is suspended and is scheduled to resume effective April 2021. The impact of this change on our operations was an increase of approximately $67 million of revenues in 2020.

- The CARES Act eliminated the scheduled nationwide reduction of $4 billion in federal Medicaid DSH allotments in FFY 2020 mandated by the Affordable Care Act and decreased the FFY 2021 DSH reduction from $8 billion to $4 billion effective December 1, 2020. Later COVID Acts eliminated the FFY 2021 DSH reduction entirely and delayed the remaining DSH reductions until FFY 2024.

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

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest payments and income tax payments, as well as cash disbursements required to respond to the COVID-19 pandemic. These fluctuations result in material intra-quarter net operating and investing uses of cash that have caused, and in the future will cause, us to use our Credit Agreement as a source of liquidity. We believe that existing cash and cash equivalents on hand, borrowing availability under our Credit Agreement, anticipated future cash provided by our operating activities and possible additional government relief packages should be adequate to meet our current cash needs. These sources of liquidity, in combination with any potential future debt incurrence, should also be adequate to finance planned capital expenditures, payments on the current portion of our long-term debt, payments to joint venture partners, including those related to put and call arrangements and other presently known operating needs.

Long-term liquidity for debt service and other purposes will be dependent on the amount of cash provided by operating activities and, subject to favorable market and other conditions, the successful completion of future borrowings and potential refinancings. However, our cash requirements could be materially affected by the use of cash in acquisitions of businesses, repurchases of securities, the exercise of put rights or other exit options by our joint venture partners, and contractual commitments to fund capital expenditures in, or intercompany borrowings to, businesses we own. In addition, liquidity could be adversely affected by a deterioration in our results of operations, including our ability to generate sufficient cash from operations, as well as by the various risks and uncertainties discussed in this section and the Risk Factors section in Part I of this report, including any costs associated with legal proceedings and government investigations.

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our consolidated balance sheets. In addition, we do not have significant exposure to floating interest rates given that all of our current long-term indebtedness has fixed rates of interest except for borrowings under our Credit Agreement.

OFF-BALANCE SHEET ARRANGEMENTS

We have no off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $186 million of standby letters of credit outstanding and guarantees at December 31, 2020.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 24 to the accompanying Consolidated Financial Statements for a discussion of recently issued accounting standards.

CRITICAL ACCOUNTING ESTIMATES

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

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

Our critical accounting estimates cover the following areas:

- Recognition of net operating revenues, including contractual allowances and implicit price concessions;
- Accruals for general and professional liability risks;
- Impairment of long-lived assets;
- Impairment of goodwill; and
- Accounting for income taxes.

REVENUE RECOGNITION

We report net patient service revenues at the amounts that reflect the consideration we expect to be entitled to in exchange for providing patient care. These amounts are due from patients, third-party payers (including managed care payers and government programs) and others, and they include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, we bill our patients and third-party payers several days after the services are performed or shortly after discharge. Revenues are recognized as performance obligations are satisfied.

We determine performance obligations based on the nature of the services we provide. We recognize revenues for performance obligations satisfied over time based on actual charges incurred in relation to total expected charges. We believe that this method provides a faithful depiction of the transfer of services over the term of performance obligations based on the

inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients in our hospitals receiving inpatient acute care services. We measure performance obligations from admission to the point when there are no further services required for the patient, which is generally the time of discharge. We recognize revenues for performance obligations satisfied at a point in time, which generally relate to patients receiving outpatient services, when: (1) services are provided; and (2) we do not believe the patient requires additional services.

We determine the transaction price based on gross charges for services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with our *Compact*, and implicit price concessions provided primarily to uninsured patients. We determine our estimates of contractual adjustments and discounts based on contractual agreements, our discount policies and historical experience. We determine our estimate of implicit price concessions based on our historical collection experience with these classes of patients using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. The financial statement effects of using this practical expedient are not materially different from an individual contract approach.

Revenues under the traditional FFS Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as IME, DGME, DSH and bad debt expense reimbursement, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates we record could change by material amounts.

We have a system and estimation process for recording Medicare net patient service revenue and estimated cost report settlements. As a result, we record accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual 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 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 generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted FFS rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at December 31, 2020, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $17 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage and payment levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. We believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for these payers and other factors that affect the estimation process.

Generally, patients who are covered by third-party payers are responsible for related co-pays, co-insurance and deductibles, which vary in amount. We also provide services to uninsured patients and offer uninsured patients a discount from standard charges. We estimate the transaction price for patients with co-pays, co-insurance and deductibles and for those who are uninsured based on historical collection experience and current market conditions. Under our *Compact* and other uninsured

discount programs, the discount offered to certain 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 at the time they are recorded through implicit price concessions based on historical collection trends for self-pay accounts and other factors that affect the estimation process. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays, co-insurance amounts and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to net patient service revenues in the period of the change.

We have provided implicit price concessions, primarily to uninsured patients and patients with co-pays, co-insurance and deductibles. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts we expect to collect based on our collection history with similar patients. Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays, co-insurance and deductibles due from patients with insurance, at the time of service while complying with all federal and state statutes and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

Based on our accounts receivable from uninsured patients and co-pays, co-insurance amounts and deductibles owed to us by patients with insurance at December 31, 2020, 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 patient accounts receivable of approximately $9 million.

ACCRUALS FOR GENERAL AND PROFESSIONAL LIABILITY RISKS

We accrue for estimated professional and general liability claims, to the extent not covered by insurance, when they are probable and can be reasonably estimated. We maintain reserves, which are based on modeled estimates for the portion of our professional liability risks, including incurred but not reported claims, to the extent we do not have insurance coverage. Our liability consists of estimates established based upon calculations using several factors, including the number of expected claims, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience and the timing of historical payments. We consider the number of expected claims and average cost per claim to be the most significant assumptions in estimating accruals for general and professional liabilities. Our liabilities are adjusted for new claims information in the period such information becomes known. Malpractice expense is recorded within other operating expenses in the accompanying Consolidated Statements of Operations. As described in Note 1 to the accompanying Consolidated Financial Statements, in the three months ended March 31, 2020, we changed our method of accounting for our estimated professional and general liability claims, as well as other claims-related liabilities. Under the new method of accounting, the liabilities are reported on an undiscounted basis whereas, previously, the liabilities were reported on a discounted basis. Accordingly, our financial statements and corresponding disclosures for the respective prior periods have been recast to reflect retrospective application of the change in accounting principle.

Our estimated reserves for professional and general liability claims will change significantly if future trends differ from projected trends. We believe it is reasonably likely for there to be a 500 basis point increase or decrease in our frequency or severity trend. Based on our reserves and other information at December 31, 2020, a 500 basis point increase in our frequency trend would increase the estimated reserves by $41 million, and a 500 basis point decrease in our frequency trend would decrease the estimated reserves by $32 million. A 500 basis point increase in our severity trend would increase the estimated reserves by $182 million, and a 500 basis point decrease in our severity trend would decrease the estimated reserves by $137 million. In addition, because of the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes, our ultimate liability for professional and general liability claims could change materially from our current estimates.

The table below shows the case reserves and incurred but not reported and loss development reserves as of December 31, 2020 and 2019:

	December 31,	
	2020	2019
Case reserves	$ 273	$ 212
Incurred but not reported and loss development reserves	705	753
Total undiscounted reserves	**$ 978**	**$ 965**

Several actuarial methods, including the incurred, paid loss development and Bornhuetter-Ferguson methods, are applied to our historical loss data to produce estimates of ultimate expected losses and the resulting incurred but not reported and loss development reserves. These methods use our specific historical claims data related to paid losses and loss adjustment expenses, historical and current case reserves, reported and closed claim counts, and a variety of hospital census information. These analyses are considered in our determination of our estimate of the professional liability claims, including the incurred but not reported and loss development reserve estimates. The determination of our estimates involves subjective judgment and could result in material changes to our estimates in future periods if our actual experience is materially different than our assumptions.

Malpractice claims generally take up to five years to settle from the time of the initial reporting of the occurrence to the settlement payment. Accordingly, the percentage of reserves at December 31, 2020 and 2019 representing unsettled claims was approximately 99% and 97%, respectively.

The following table, which includes both our continuing and discontinued operations, presents the amount of our accruals for professional and general liability claims and the corresponding activity therein:

	Years Ended December 31,	
	2020	2019
Accrual for professional and general liability claims, beginning of the year	$ 965	$ 951
Less losses recoverable from re-insurance and excess insurance carriers	(86)	(31)
Expense related to:(1)		
Current year	195	193
Prior years	120	155
Total incurred loss and loss expense	315	348
Paid claims and expenses related to:		
Current year	(3)	(8)
Prior years	(263)	(381)
Total paid claims and expenses	(266)	(389)
Plus losses recoverable from re-insurance and excess insurance carriers	50	86
Accrual for professional and general liability claims, end of year	**$ 978**	**$ 965**

(1) Total malpractice expense for continuing operations, including premiums for insured coverage and recoveries from third parties, was $320 million and $356 million in the years ended December 31, 2020 and 2019, respectively.

IMPAIRMENT OF LONG-LIVED ASSETS

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment charge if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the following risks:

- future financial results of our hospitals, which can be impacted by volumes of insured patients and declines in commercial managed care patients, terms of managed care payer arrangements, our ability to collect amounts due from uninsured and managed care payers, loss of volumes as a result of competition, and our ability to manage costs such as labor costs, which can be adversely impacted by union activity and the shortage of experienced nurses;

- changes in payments from governmental healthcare programs and in government regulations such as reductions to Medicare and Medicaid payment rates resulting from government legislation or rule-making or from budgetary challenges of states in which we operate;

- how the hospitals are operated in the future; and

- the nature of the ultimate disposition of the assets.

During the year ended December 31, 2020, we recorded $92 million of impairment charges, consisting of $76 million to write-down hospital buildings located in one of our Hospital Operations segment's markets to their estimated fair values and $16 million of other impairment charges. Of the total impairment charges recognized for the year ended December 31, 2020, $79 million related to our Hospital Operations segment, $12 million related to our Ambulatory Care segment, and $1 million related to our Conifer segment.

During the year ended December 31, 2019, we recorded $42 million of impairment charges, consisting of $26 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Memphis-area facilities and $16 million of other impairment charges. Of the total impairment charges recognized for the year ended December 31, 2019, $31 million related to our Hospital Operations segment, $6 million related to our Ambulatory Care segment, and $5 million related to our Conifer segment.

In our most recent impairment analysis as of December 31, 2020, we had one asset group, including three hospitals and related operations, with an aggregate carrying value of long-lived assets of $151 million whose estimated undiscounted future cash flows exceeded the carrying value of long-lived assets by approximately 160%. The estimated undiscounted future cash flows of these long-lived asset groups may not be considered to be substantially in excess of cash flows necessary to recover the carrying values of their long-lived assets. Future adverse trends that necessitate changes in the estimates of undiscounted future cash flows could result in the estimated undiscounted future cash flows being less than the carrying values of the long-lived assets, which would require a fair value assessment, and if the fair value amount is less than the carrying value of the long-lived assets, material impairment charges could result.

IMPAIRMENT OF GOODWILL

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level, as defined by applicable accounting standards, when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals or outpatient facilities, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

At December 31, 2020, our continuing operations consisted of three reportable segments, Hospital Operations, Ambulatory Care and Conifer. Our segments are reporting units used to perform our goodwill impairment analysis. We completed our annual impairment tests for goodwill as of October 1, 2020.

The allocated goodwill balance related to our Hospital Operations segment totals $2.945 billion. For the Hospital Operations segment, we performed a qualitative analysis and concluded that it was more likely than not that the fair value of the reporting unit exceeded its carrying value. Factors considered in the analysis included recent and estimated future operating trends.

The allocated goodwill balance related to our Ambulatory Care segment totals $5.258 billion. For the Ambulatory Care segment, we performed a qualitative analysis and concluded that it was more likely than not that the fair value of the reporting unit exceeded its carrying value. Factors considered in the analysis included recent and estimated future operating trends.

The allocated goodwill balance related to our Conifer segment totals $605 million. For the Conifer segment, we performed a qualitative analysis and concluded that it was more likely than not that the fair value of the reporting unit exceeded its carrying value. Factors considered in the analysis included recent and estimated future operating trends.

ACCOUNTING FOR INCOME TAXES

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;
- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

During the year ended December 31, 2020, the valuation allowance decreased by $226 million, including a decrease of $211 million due to limitations on the tax deductibility of interest expense, a decrease of $1 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and a decrease of $14 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2020 was $55 million. During the year ended December 31, 2019, the valuation allowance increased by $133 million, including an increase of $130 million due to limitations on the tax deductibility of interest expense, a decrease of $2 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and an increase of $5 million due to changes in expected realizability of deferred tax assets. The remaining balance in the valuation allowance at December 31, 2019 was $281 million. Deferred tax assets relating to interest expense limitations under Internal Revenue Code Section 163(j) have a full valuation allowance because the interest expense carryovers are not expected to be utilized in the foreseeable future.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

While we believe we have adequately provided for our income tax receivables or liabilities and our deferred tax assets or liabilities, adverse determinations by taxing authorities or changes in tax laws and regulations could have a material adverse effect on our consolidated financial position, results of operations or cash flows.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The following table presents information about certain of our market-sensitive financial instruments at December 31, 2020. The fair values were determined based on quoted market prices for the same or similar instruments. The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized discounts and issue costs are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2021	2022	2023	2024	2025	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed-rate long-term debt	$ 145	$ 100	$ 1,925	$ 2,494	$ 2,607	$ 8,624	$ 15,895	$ 16,605
Average effective interest rates	4.5 %	5.2 %	7.3 %	4.9 %	6.4 %	5.8 %	5.9 %	

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

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

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

MANAGEMENT REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

To Our Shareholders:

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended. Management assessed the effectiveness of Tenet's internal control over financial reporting as of December 31, 2020. This assessment was performed under the supervision of and with the participation of management, including the chief executive officer and chief financial officer.

In making this assessment, management used criteria based on the framework in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on the assessment using the COSO framework, management concluded that Tenet's internal control over financial reporting was effective as of December 31, 2020.

As more fully described in Note 22 to the consolidated Financial Statements, in December 2020, subsidiaries of USPI Holding Company, Inc., in which we own 95% of the voting common stock, acquired interests in 45 ambulatory surgery centers ("SCD Centers"). We have excluded all of the SCD Centers' operations from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. The SCD Centers represent approximately 6% of total assets and less than 1% of net operating revenues of our consolidated financial statement amounts for the year ended December 31, 2020. We expect that our internal control system will be fully implemented at our SCD Centers during 2021 and correspondingly evaluated by us for effectiveness.

Tenet's internal control over financial reporting as of December 31, 2020 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report, which is included herein. Deloitte & Touche LLP has also audited Tenet's Consolidated Financial Statements as of and for the year ended December 31, 2020, and that firm's audit report on such Consolidated Financial Statements is also included herein.

Internal control over financial reporting cannot provide absolute assurance of achieving financial reporting objectives because of its inherent limitations. Internal control over financial reporting is a process that involves human diligence and compliance and is subject to lapses in judgment and breakdowns resulting from human failures. Internal control over financial reporting also can be circumvented by collusion or improper management override. Because of such limitations, there is a risk that material misstatements may not be prevented or detected on a timely basis by internal control over financial reporting. However, these inherent limitations are known features of the financial reporting process. Therefore, it is possible to design into the process safeguards to reduce, though not eliminate, this risk.

/s/ RONALD A. RITTENMEYER
Ronald A. Rittenmeyer
Executive Chairman and Chief Executive Officer
February 19, 2021

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Executive Vice President and Chief Financial Officer
February 19, 2021

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of Tenet Healthcare Corporation

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2020, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2020 of the Company and our report dated February 19, 2021, expressed an unqualified opinion on those financial statements.

As described in Item 8, Management Report on Internal Control Over Financial Reporting, management excluded from its assessment the internal control over financial reporting at 45 ambulatory surgery centers ("SCD Centers"), which were acquired in December 2020, which constitute approximately 6% of consolidated total assets and less than 1% of consolidated net operating revenues as of and for the year ended December 31, 2020. Accordingly, our audit did not include the internal control over financial reporting at the SCD Centers.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting
A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 19, 2021

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of Tenet Healthcare Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2020 and 2019, the related consolidated statements of operations, other comprehensive income (loss), changes in equity, and cash flows for each of the three years in the period ended December 31, 2020, and the related notes and the consolidated financial statement schedule listed in the Index at Item 15 (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 19, 2021, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current-period audit of the financial statements that were communicated or required to be communicated to the audit committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Accounts Receivable and Net Operating Revenues— Refer to Notes 1, 3 and 15 to the financial statements

Critical Audit Matter Description

Management reports net patient service revenues and accounts receivable at the amounts that reflect the consideration to which they expect to be entitled for providing patient care. As of and for the year ended December 31, 2020, the balances for accounts receivable and net patient service revenues are $2,690 million and $15,690 million, respectively. This transaction price is based on gross charges for services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Company's Compact with Uninsured Patients, and implicit price concessions provided primarily to uninsured patients. The implicit price concessions are estimates developed by management based on their historical collection experience with these classes of patients using a portfolio approach.

Given the judgments necessary to estimate the implicit price concessions to determine the amount of net revenues recognized and the value of patient accounts receivable as a result of inherent subjectivity in collection trends from changes

in the economy, patient volumes, amounts to be paid by patients with insurance and other factors, auditing such estimates involved especially subjective judgments.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to management's estimates of the implicit price concessions used to determine the value of net patient service revenues and accounts receivable included the following, among others:

- We tested the effectiveness of controls over net patient service revenues and the valuation of accounts receivable, including those over the historical collections data and management's analysis of their historical collection experience and judgments applied to develop their assumptions for implicit price concessions.
- We evaluated the methods and assumptions used by management to estimate the implicit price concessions by:
    - Testing the underlying data that served as the basis for the implicit price concession rates developed by management, including the historical collections data within the classes of patients, to evaluate whether the inputs to management's estimate were reasonable.
    - Comparing management's prior-year expectation to actual amounts recorded during the current year.
- We developed an independent estimate using historical collection data for each class of patients. We then compared the result to the implicit price concession estimate developed by management to evaluate the reasonableness of accounts receivable and revenues.

Property and Professional and General Liability Insurance – Professional and General Liability Reserves — Refer to Notes 1 and 16 to the financial statements

Critical Audit Matter Description

Management records an accrual for the portion of their professional and general liability risks, including incurred but not reported claims, for which they are self-insured and that are probable and can be reasonably estimated. As of December 31, 2020, the accrual for professional and general liability is $978 million. This accrual is estimated based on internal and third-party modeled estimates of projected payments using case-specific facts and circumstances and the Company's historical claim loss reporting, claim development and settlement patterns, reported and closed claim counts, and a variety of hospital census information.

Given the subjectivity of estimating the projected liability of reported and unreported claims, auditing the professional and general liability reserves involved especially subjective judgment.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to the professional and general liability reserves included the following, among others:

- We tested the effectiveness of controls related to the professional and general liability reserves, including those over the estimation of the projected liability of reported and unreported claims.
- We evaluated the data used by management to estimate the professional and general liability reserves by:
    - Testing the underlying data that served as the basis for the internal and third-party actuarial analyses, including historical claims, to evaluate that the inputs to the actuarial estimates were reasonable.
    - Comparing management's prior-year recorded balance to actual losses incurred during the current year.

With the assistance of our internal actuarial specialists, we developed an independent range of estimates of the professional and general liability reserves, using loss data, historical and industry claim development factors, among other factors, and compared our estimates to management's estimates.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 19, 2021

We have served as the Company's auditor since 2007.

CONSOLIDATED BALANCE SHEETS
Dollars in Millions

	December 31, 2020	December 31, 2019
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,446	$ 262
Accounts receivable	2,690	2,743
Inventories of supplies, at cost	368	310
Income tax receivable	1	10
Assets held for sale	140	387
Other current assets	1,502	1,369
Total current assets	**7,147**	**5,081**
Investments and other assets	2,534	2,369
Deferred income taxes	325	183
Property and equipment, at cost, less accumulated depreciation and amortization ($6,043 at December 31, 2020 and $5,498 at December 31, 2019)	6,692	6,878
Goodwill	8,808	7,252
Other intangible assets, at cost, less accumulated amortization ($1,284 at December 31, 2020 and $1,092 at December 31, 2019)	1,600	1,602
Total assets	**$ 27,106**	**$ 23,365**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 145	$ 171
Accounts payable	1,207	1,204
Accrued compensation and benefits	942	877
Professional and general liability reserves	243	330
Accrued interest payable	248	245
Liabilities held for sale	70	44
Contract liabilities	659	61
Other current liabilities	1,333	1,273
Total current liabilities	**4,847**	**4,205**
Long-term debt, net of current portion	15,574	14,580
Professional and general liability reserves	735	635
Defined benefit plan obligations	497	560
Deferred income taxes	29	27
Contract liabilities – long-term	918	18
Other long-term liabilities	1,617	1,397
Total liabilities	**24,217**	**21,422**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,952	1,506
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 154,407,524 shares issued at December 31, 2020 and 152,540,815 shares issued at December 31, 2019	7	7
Additional paid-in capital	4,844	4,760
Accumulated other comprehensive loss	(281)	(257)
Accumulated deficit	(2,128)	(2,513)
Common stock in treasury, at cost, 48,337,947 shares at December 31, 2020 and 48,344,195 shares at December 31, 2019	(2,414)	(2,414)
Total shareholders' equity (deficit)	**28**	**(417)**
Noncontrolling interests	**909**	**854**
Total equity	**937**	**437**
Total liabilities and equity	**$ 27,106**	**$ 23,365**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts

	Years Ended December 31,		
	2020	2019	2018
Net operating revenues	**$ 17,640**	**$ 18,479**	**$ 18,313**
Grant income	**882**	**—**	**—**
Equity in earnings of unconsolidated affiliates	**169**	**175**	**150**
Operating expenses:			
Salaries, wages and benefits	8,418	8,698	8,633
Supplies	2,982	3,057	3,004
Other operating expenses, net	4,125	4,171	4,267
Depreciation and amortization	857	850	802
Impairment and restructuring charges, and acquisition-related costs	290	185	209
Litigation and investigation costs	44	141	38
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(14)	15	(127)
Operating income	**1,989**	**1,537**	**1,637**
Interest expense	(1,003)	(985)	(1,004)
Other non-operating income (expense), net	1	(5)	(5)
Gain (loss) from early extinguishment of debt	(316)	(227)	1
Income from continuing operations, before income taxes	**671**	**320**	**629**
Income tax benefit (expense)	97	(160)	(173)
Income from continuing operations, before discontinued operations	**768**	**160**	**456**
Discontinued operations:			
Income from operations	—	15	4
Income tax expense	—	(4)	(1)
Income from discontinued operations	**—**	**11**	**3**
Net income	**768**	**171**	**459**
Less: Net income available to noncontrolling interests	369	386	355
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 399**	**$ (215)**	**$ 104**
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders			
Income (loss) from continuing operations, net of tax	$ 399	$ (226)	$ 101
Income from discontinued operations, net of tax	—	11	3
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 399**	**$ (215)**	**$ 104**
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ 3.80	$ (2.19)	$ 0.99
Discontinued operations	—	0.11	0.03
	$ 3.80	**$ (2.08)**	**$ 1.02**
Diluted			
Continuing operations	$ 3.75	$ (2.19)	$ 0.97
Discontinued operations	—	0.11	0.03
	$ 3.75	**$ (2.08)**	**$ 1.00**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	105,010	103,398	102,110
Diluted	106,263	103,398	103,881

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME (LOSS)
Dollars in Millions

	Years Ended December 31,		
	2020	2019	2018
Net income	$ 768	$ 171	$ 459
Other comprehensive income (loss):			
Adjustments for defined benefit plans	(41)	(52)	(29)
Amortization of net actuarial loss included in other non-operating expense, net	9	10	14
Unrealized gains on debt securities held as available-for-sale	1	—	—
Sale of foreign subsidiary	—	—	37
Foreign currency translation adjustments	—	—	(4)
Other comprehensive income (loss) before income taxes	**(31)**	**(42)**	**18**
Income tax benefit related to items of other comprehensive income (loss)	7	8	6
Total other comprehensive income (loss), net of tax	**(24)**	**(34)**	**24**
Comprehensive net income	**744**	**137**	**483**
Less: Comprehensive income available to noncontrolling interests	**369**	**386**	**355**
Comprehensive income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 375**	**$ (249)**	**$ 128**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
Dollars in Millions,
Share Amounts in Thousands

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock							
	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balances at December 31, 2017	**100,972**	**$ 7**	**$ 4,859**	**$ (204)**	**$ (2,446)**	**$ (2,419)**	**$ 686**	**$ 483**
Net income	—	—	—	—	104	—	165	269
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(148)	(148)
Other comprehensive income	—	—	—	24	—	—	—	24
Accretion of redeemable noncontrolling interests	—	—	(173)	—	—	—	—	(173)
Purchases of businesses and noncontrolling interests, net	—	—	3	—	—	—	103	106
Cumulative effect of accounting change	—	—	—	(43)	43	—	—	—
Stock-based compensation expense, tax benefit and issuance of common stock	1,565	—	58	—	—	5	—	63
Balances at December 31, 2018	**102,537**	**7**	**4,747**	**(223)**	**(2,299)**	**(2,414)**	**806**	**624**
Net income (loss)	—	—	—	—	(215)	—	194	(21)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(162)	(162)
Other comprehensive loss	—	—	—	(34)	—	—	—	(34)
Accretion of redeemable noncontrolling interests	—	—	(18)	—	—	—	—	(18)
Purchases (sales) of businesses and noncontrolling interests, net	—	—	(7)	—	—	—	16	9
Cumulative effect of accounting change	—	—	—	—	1	—	—	1
Stock-based compensation expense, tax benefit and issuance of common stock	1,660	—	38	—	—	—	—	38
Balances at December 31, 2019	**104,197**	**7**	**4,760**	**(257)**	**(2,513)**	**(2,414)**	**854**	**437**
Net income	—	—	—	—	399	—	183	582
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(152)	(152)
Other comprehensive loss	—	—	—	(24)	—	—	—	(24)
Accretion of redeemable noncontrolling interests	—	—	(4)	—	—	—	—	(4)
Purchases of businesses and noncontrolling interests, net	—	—	27	—	—	—	24	51
Cumulative effect of accounting change	—	—	—	—	(14)	—	—	(14)
Stock-based compensation expense, tax benefit and issuance of common stock	1,873	—	61	—	—	—	—	61
Balances at December 31, 2020	**106,070**	**$ 7**	**$ 4,844**	**$ (281)**	**$ (2,128)**	**$ (2,414)**	**$ 909**	**$ 937**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2020	2019	2018
Net income	**$ 768**	**$ 171**	**$ 459**
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	857	850	802
Deferred income tax (benefit) expense	(128)	144	147
Stock-based compensation expense	44	42	46
Impairment and restructuring charges, and acquisition-related costs	290	185	209
Litigation and investigation costs	44	141	38
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(14)	15	(127)
Loss (gain) from early extinguishment of debt	316	227	(1)
Equity in earnings of unconsolidated affiliates, net of distributions received	(37)	(32)	(12)
Amortization of debt discount and debt issuance costs	38	35	45
Pre-tax income from discontinued operations	—	(15)	(4)
Other items, net	(29)	(15)	(21)
Changes in cash from operating assets and liabilities:			
Accounts receivable	195	(247)	(134)
Inventories and other current assets	(145)	(94)	17
Income taxes	19	8	(3)
Accounts payable, accrued expenses, contract liabilities and other current liabilities	1,302	12	(142)
Other long-term liabilities	221	3	(102)
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(333)**	**(192)**	**(163)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(1)**	**(5)**	**(5)**
Net cash provided by operating activities	**3,407**	**1,233**	**1,049**
Cash flows from investing activities:			
Purchases of property and equipment — continuing operations	(540)	(670)	(617)
Purchases of businesses or joint venture interests, net of cash acquired	(1,177)	(25)	(113)
Proceeds from sales of facilities and other assets — continuing operations	77	63	543
Proceeds from sales of facilities and other assets — discontinued operations	—	17	—
Proceeds from sales of marketable securities, long-term investments and other assets	59	82	199
Purchases of marketable securities and equity investments	(44)	(62)	(148)
Other long-term assets	(1)	(24)	15
Other items, net	18	—	6
Net cash used in investing activities	**(1,608)**	**(619)**	**(115)**
Cash flows from financing activities:			
Repayments of borrowings under credit facility	(740)	(2,640)	(950)
Proceeds from borrowings under credit facility	740	2,640	950
Repayments of other borrowings	(3,293)	(6,131)	(312)
Proceeds from other borrowings	3,818	5,719	23
Debt issuance costs	(48)	(70)	—
Distributions paid to noncontrolling interests	(287)	(307)	(288)
Proceeds from sale of noncontrolling interests	14	21	20
Purchases of noncontrolling interests	(39)	(11)	(647)
Proceeds from exercise of stock options and employee stock purchase plan	23	12	16
Medicare advances and grants received by unconsolidated affiliates	187	—	—
Other items, net	10	4	54
Net cash provided by (used in) financing activities	**385**	**(763)**	**(1,134)**
Net increase (decrease) in cash and cash equivalents	2,184	(149)	(200)
Cash and cash equivalents at beginning of period	262	411	611
Cash and cash equivalents at end of period	**$ 2,446**	**$ 262**	**$ 411**
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (962)	$ (946)	$ (976)
Income tax payments, net	$ (12)	$ (12)	$ (25)

See accompanying Notes to Consolidated Financial Statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company headquartered in Dallas, Texas. Through an expansive care network that includes USPI Holding Company, Inc. ("USPI"), at December 31, 2020, we operated 65 hospitals and over 550 other healthcare facilities, including surgical hospitals, ambulatory surgery centers ("ASCs"), urgent care and imaging centers, and other care sites and clinics. We hold noncontrolling interests in 107 of these facilities, which are recorded using the equity method of accounting. We also operate Conifer Health Solutions, LLC through our Conifer Holdings, Inc. ("Conifer") subsidiary, which provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients.

Effective June 16, 2015, we completed a transaction that combined our freestanding ambulatory surgery and imaging center assets with the surgical facility assets of United Surgical Partners International, Inc. into our joint venture, USPI. In April 2016, we paid $127 million to purchase additional shares, which increased our ownership interest in USPI from 50.1% to approximately 56.3%. In July 2017, we paid $716 million for the purchase of additional shares and the final adjustment to the 2016 purchase price, which increased our ownership interest in USPI to 80.0%. In April 2018, we paid approximately $630 million for the purchase of an additional 15% ownership interest in USPI and the final adjustment to the 2017 purchase price, which increased our ownership interest in USPI to 95%, where it remained at December 31, 2020 and 2019.

Basis of Presentation

Our Consolidated Financial Statements include the accounts of Tenet and its wholly owned and majority-owned subsidiaries. We eliminate intercompany accounts and transactions in consolidation, and we include the results of operations of businesses that are newly acquired in purchase transactions from their dates of acquisition. We account for significant investments in other affiliated companies using the equity method. Unless otherwise indicated, all financial and statistical data included in these notes to our Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts).

Effective January 1, 2020, we adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2016-13, "Financial Instruments—Credit Losses (Topic 326) Measurement of Credit Losses on Financial Instruments" ("ASU 2016-13") using the modified retrospective transition approach as of the period of adoption. The amendments in this ASU required a financial asset (or a group of financial assets) measured at amortized cost basis to be presented at the net amount expected to be collected. The allowance for credit losses is a valuation account that is deducted from the amortized cost basis of the financial asset(s) to present the net carrying value at the amount expected to be collected on the financial asset. Upon adoption of ASU 2016-13 on January 1, 2020, we recorded a cumulative effect adjustment to increase accumulated deficit by $14 million.

Effective January 1, 2019, we adopted ASU 2016-02, "Leases (Topic 842)" ("ASU 2016-02") using the modified retrospective transition approach as of the period of adoption. Our financial statements for periods prior to January 1, 2019 were not modified for the application of the new lease accounting standard. The main difference between the guidance in ASU 2016-02 and previous accounting principles generally accepted in the United States of America ("GAAP") is the recognition of lease assets and lease liabilities on the balance sheet by lessees for those leases classified as operating leases under previous GAAP. Upon adoption of ASU 2016-02, we recorded $822 million of right-of-use assets, net of deferred rent, associated with operating leases in investments and other assets in our consolidated balance sheet, $147 million of current liabilities associated with operating leases in other current liabilities in our consolidated balance sheet and $715 million of long-term liabilities associated with operating leases in other long-term liabilities in our consolidated balance sheet. We also recognized $1 million of cumulative effect adjustment that decreased accumulated deficit at January 1, 2019.

Effective January 1, 2018, we adopted the FASB ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09") using a modified retrospective method of application to all contracts existing on January 1, 2018. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. For our Hospital Operations and Other ("Hospital Operations") and Ambulatory Care segments, the adoption of ASU 2014-09 resulted in changes to our presentation and disclosure of revenue primarily related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related

to uninsured patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding reduction in the amounts presented as provision for doubtful accounts. For the year ended December 31, 2018, we recorded approximately $1.422 billion of implicit price concessions as a direct reduction of net operating revenues that would have been recorded as provision for doubtful accounts prior to the adoption of ASU 2014-09. At January 1, 2018, we reclassified $171 million of revenues related to patients who were still receiving inpatient care in our facilities at that date from accounts receivable, less allowance for doubtful accounts, to contract assets, which are included in other current assets in our consolidated balance sheets. The adoption of ASU 2014-09 also resulted in changes to our presentation and disclosure of customer contract assets and liabilities and the assessment of variable consideration under customer contracts.

Also effective January 1, 2018, we early adopted ASU 2018-02, "Income Statement—Reporting Comprehensive Income (Topic 220)" ("ASU 2018-02"), which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded income tax effects resulting from the Tax Cuts and Jobs Act and requires certain disclosures about stranded income tax effects. We applied the amendments in ASU 2018-02 in the period of adoption, resulting in a reclassification that decreased accumulated deficit and increased accumulated other comprehensive loss by $36 million of stranded income tax effects in the year ended December 31, 2018.

In addition, we adopted ASU 2016-01, "Financial Instruments—Overall (Subtopic 825-10) Recognition and Measurement of Financial Assets and Liabilities" ("ASU 2016-01") effective January 1, 2018, which supersedes the guidance to classify equity securities with readily determinable fair values to different categories (that is, trading or available-for-sale) and requires equity securities (including other ownership interests, such as partnerships, unincorporated joint ventures and limited liability companies) to be measured at fair value with changes in the fair value recognized through net income. Upon adoption of ASU 2016-01 on January 1, 2018, we recorded a cumulative effect adjustment to decrease accumulated deficit by $7 million for unrealized gains on equity securities.

Certain prior-year amounts have been reclassified to conform to the current year presentation. In our consolidated balance sheets, contract liabilities and contract liabilities – long-term, primarily related to Medicare advance payments we received, are now presented separately due to the fact that the balances increased substantially in 2020. Additionally, our financial statements and corresponding disclosures for prior periods have been recast to reflect retrospective application of the change in accounting principle discussed in the Professional and General Liability Reserves section of this note.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Although we believe all adjustments considered necessary for a fair presentation have been included, actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Professional and General Liability Reserves

We accrue for estimated professional and general liability claims when they are probable and can be reasonably estimated. The accrual, which includes an estimate for incurred but not reported claims, is updated each quarter based on a model of projected payments using case-specific facts and circumstances and our historical loss reporting, development and settlement patterns. To the extent that subsequent claims information varies from our estimates, the liability is adjusted in the period such information becomes available. Malpractice expense is presented within other operating expenses in the accompanying Consolidated Statements of Operations.

In March 2020, we changed our method of accounting for our estimated professional and general liability claims. Under the new method of accounting, the liabilities are reported on an undiscounted basis whereas, previously, the liabilities were reported on a discounted basis. We believe that the undiscounted presentation is preferable because it simplifies the accounting for the liabilities, thereby increasing understandability of our financial results and financial condition, is consistent with the manner in which management evaluates our business, and results in an accounting method and financial statement presentation that is consistent with our key peers.

Accordingly, our financial statements and corresponding disclosures for the respective prior periods have been recast to reflect retrospective application of the change in accounting principle. We recorded the cumulative effect of the change in accounting principle as an increase of $44 million to accumulated deficit as of January 1, 2017. This change increased our accumulated deficit by $46 million, $63 million and $56 million at December 31, 2019, 2018 and 2017, respectively.

The following tables present the effects of the change in accounting principle to our financial statements:

Consolidated Balance Sheet:

	As Reported	Effect of Change in Accounting Principle	As Adjusted
At December 31, 2019:			
Deferred income taxes	$ 169	$ 14	$ 183
Professional and general liability reserves	$ 585	$ 50	$ 635
Other long-term liabilities	$ 1,387	$ 10	$ 1,397
Accumulated deficit	$ (2,467)	$ (46)	$ (2,513)

Consolidated Statements of Operations (in millions, except for per-share amounts):

	Year Ended December 31, 2020		
	Prior to Change in Accounting Principle	Effect of Change in Accounting Principle	As Reported
Salaries, wages and benefits	$ 8,425	$ (7)	$ 8,418
Other operating expenses, net	$ 4,159	$ (34)	$ 4,125
Operating income	$ 1,948	$ 41	$ 1,989
Income tax benefit	$ 107	$ (10)	$ 97
Net income	$ 737	$ 31	$ 768
Net income from continuing operations available to Tenet Healthcare Corporation common shareholders	$ 368	$ 31	$ 399
Earnings per share available to Tenet Healthcare Corporation common shareholders from continuing operations:			
Basic	$ 3.50	$ 0.30	$ 3.80
Diluted	$ 3.46	$ 0.29	$ 3.75

	Year Ended December 31, 2019		
	As Reported	Effect of Change in Accounting Principle	As Adjusted
Salaries, wages and benefits	$ 8,704	$ (6)	$ 8,698
Other operating expenses, net	$ 4,189	$ (18)	$ 4,171
Operating income	$ 1,513	$ 24	$ 1,537
Income tax expense	$ (153)	$ (7)	$ (160)
Net income	$ 154	$ 17	$ 171
Net loss from continuing operations attributable to Tenet Healthcare Corporation common shareholders	$ (243)	$ 17	$ (226)
Loss per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations:			
Basic	$ (2.35)	$ 0.16	$ (2.19)
Diluted	$ (2.35)	$ 0.16	$ (2.19)

	Year Ended December 31, 2018		
	As Reported	Effect of Change in Accounting Principle	As Adjusted
Salaries, wages and benefits	$ 8,634	$ (1)	$ 8,633
Other operating expenses, net	$ 4,256	$ 11	$ 4,267
Operating income	$ 1,647	$ (10)	$ 1,637
Income tax expense	$ (176)	$ 3	$ (173)
Net income	$ 466	$ (7)	$ 459
Net income from continuing operations available to Tenet Healthcare Corporation common shareholders	$ 108	$ (7)	$ 101
Earnings per share available to Tenet Healthcare Corporation common shareholders from continuing operations:			
Basic	$ 1.06	$ (0.07)	$ 0.99
Diluted	$ 1.04	$ (0.07)	$ 0.97

Consolidated Statements of Cash Flows:

	Prior to Change in Accounting Principle	Effect of Change in Accounting Principle	As Reported
Year Ended December 31, 2020:			
Net income	$ 737	$ 31	$ 768
Deferred income tax benefit	$ (138)	$ 10	$ (128)
Accounts payable, accrued expenses and other current liabilities	$ 1,343	$ (41)	$ 1,302
Net cash provided by operating activities	$ 3,407	$ —	$ 3,407

	As Reported	Effect of Change in Accounting Principle	As Adjusted
Year Ended December 31, 2019:			
Net income	$ 154	$ 17	$ 171
Deferred income tax expense	$ 137	$ 7	$ 144
Accounts payable, accrued expenses and other current liabilities	$ 36	$ (24)	$ 12
Net cash provided by operating activities	$ 1,233	$ —	$ 1,233

	As Reported	Effect of Change in Accounting Principle	As Adjusted
Year Ended December 31, 2018:			
Net income	$ 466	$ (7)	$ 459
Deferred income tax expense	$ 150	$ (3)	$ 147
Accounts payable, accrued expenses and other current liabilities	$ (152)	$ 10	$ (142)
Net cash provided by operating activities	$ 1,049	$ —	$ 1,049

COVID-19 Pandemic

In 2020, the COVID-19 pandemic impacted all three segments of our business, as well as our patients, communities and employees. The spread of COVID-19 and the ensuing response of federal, state and local authorities beginning in March 2020 resulted in a material reduction in our patient volumes and also adversely affected our net operating revenues in the year ended December 31, 2020. Federal, state and local authorities have taken several actions designed to assist healthcare providers in providing care to COVID-19 and other patients and to mitigate the adverse economic impact of the COVID-19 pandemic. Legislative actions taken by the federal government include the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which was signed into law on March 27, 2020, the Paycheck Protection Program and Health Care Enhancement Act (the "PPP Act"), which was signed into law on April 24, 2020, the Continuing Appropriations Act, 2021 and Other Extensions Act (the "Continuing Appropriations Act"), which was signed into law October 1, 2020, and the Consolidated Appropriations Act, 2021 (the "Consolidated Appropriations Act" and, collectively, with the CARES Act, the PPP Act, and the Continuing Appropriations Act, the "COVID Acts"), which was signed into law on December 27, 2020. Through the COVID Acts the federal government has authorized $178 billion in payments to be distributed through the Public Health and Social Services Emergency Fund ("Provider Relief Fund" or "PRF"). Additionally, the COVID Acts revised the Medicare accelerated

payment program in an attempt to disburse payments to hospitals and other care providers more quickly to mitigate the shortfalls due to delays in non-essential procedures, as well as staffing and billing disruptions. Our participation in these programs and related accounting policies are summarized below.

Grant Income. During the year ended December 31, 2020, we received cash payments of $974 million from the Provider Relief Fund and state and local grant programs, including $74 million received by our unconsolidated affiliates. Payments from the PRF are not loans and, therefore, they are not subject to repayment. However, as a condition to receiving distributions, providers must agree to certain terms and conditions, including, among other things, that the funds are being used for lost revenues and unreimbursed COVID-related costs as defined by the U.S. Department of Health and Human Services ("HHS"), and that the providers will not seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. All recipients of PRF payments are required to comply with the reporting requirements described in the terms and conditions and as determined by HHS.

We recognize grant payments as income when there is reasonable assurance that we have complied with the conditions associated with the grant. Our estimates could change materially in the future based on our operating performance or COVID-19 activities, as well as the government's evolving grant compliance guidance. Grant income recognized by our Hospital Operations and Ambulatory Care segments is presented in grant income and grant income recognized through our unconsolidated affiliates is presented in equity in earnings of unconsolidated affiliates in the accompanying Consolidated Statements of Operations for the year ended December 31, 2020. During the year ended December 31, 2020, we recognized grant income of $823 million in our Hospital Operations segment, and $59 million in our Ambulatory Care segment. We recognized an additional $17 million of Provider Relief Fund income from our unconsolidated affiliates during this period. We have deferred $18 million of payments, which amount is recorded in other current liabilities on our Consolidated Balance Sheet at December 31, 2020.

Medicare Accelerated Payment Program. In certain circumstances, when a hospital is experiencing financial difficulty due to delays in receiving payment for the Medicare services it provided, it may be eligible for an accelerated or advance payment pursuant to the Medicare accelerated payment program. The COVID Acts revised the Medicare accelerated payment program in an attempt to disburse payments to healthcare providers more quickly. Recipients may retain the accelerated payments for one year from the date of receipt before recoupment commences, which will be effectuated by a 25% offset of claims payments for 11 months, followed by a 50% offset for the succeeding six months. At the end of the 29-month period, interest on the unpaid balance will be assessed at 4.00% per annum.

In the year ended December 31, 2020, our Hospital Operations and Ambulatory Care segments received advance payments from the Medicare accelerated payment program following expansion of the program under the COVID Acts. Advances totaling $603 million are included in contract liabilities and $902 million are included in contract liabilities – long term in the accompanying Consolidated Balance Sheet at December 31, 2020.

Deferral of Employment Tax Payments. The COVID Acts permitted employers to defer payment of the 6.2% employer Social Security tax beginning March 27, 2020 through December 31, 2020. Deferred tax amounts are required to be paid in equal amounts over two years, with payments due in December 2021 and December 2022. During the year ended December 31, 2020, we deferred Social Security tax payments totaling $275 million pursuant to this provision.

Translation of Foreign Currencies

During the year ended December 31, 2019, we formed our Global Business Center ("GBC") in the Philippines. The GBC's accounts are measured in its local currency (the Philippine peso) and then translated into U.S. dollars. We divested European Surgical Partners Limited ("Aspen") in August 2018; prior to that time, Aspen's accounts were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities denominated in foreign currency are translated using the current rate of exchange at the balance sheet date. Results of operations denominated in foreign currency are translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates are accumulated in shareholders' equity.

Net Operating Revenues

We recognize net operating revenues in the period in which we satisfy our performance obligations under contracts by transferring services to our customers. Net operating revenues are recognized in the amounts we expect to be entitled to, which are the transaction prices allocated for the distinct services. Net operating revenues for our Hospital Operations and Ambulatory Care segments primarily consist of net patient service revenues, principally for patients covered by Medicare, Medicaid,

managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("*Compact*") and other uninsured discount and charity programs. Net operating revenues for our Conifer segment primarily consist of revenues from providing revenue cycle management services to health systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

Net Patient Service Revenues—We report net patient service revenues at the amounts that reflect the consideration we expect to be entitled to in exchange for providing patient care. These amounts are due from patients, third-party payers (including managed care payers and government programs) and others, and they include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, we bill our patients and third-party payers several days after the services are performed or shortly after discharge. Revenues are recognized as performance obligations are satisfied.

We determine performance obligations based on the nature of the services we provide. We recognize revenues for performance obligations satisfied over time based on actual charges incurred in relation to total expected charges. We believe that this method provides a faithful depiction of the transfer of services over the term of performance obligations based on the inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients in our hospitals receiving inpatient acute care services. We measure performance obligations from admission to the point when there are no further services required for the patient, which is generally the time of discharge. We recognize revenues for performance obligations satisfied at a point in time, which generally relate to patients receiving outpatient services, when: (1) services are provided; and (2) we do not believe the patient requires additional services.

Because our patient service performance obligations relate to contracts with a duration of less than one year, we have elected to apply the optional exemption provided in FASB Accounting Standards Codification ("FASB ASC") 606-10-50-14(a) and, therefore, we are not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

We determine the transaction price based on gross charges for services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with our *Compact*, and implicit price concessions provided primarily to uninsured patients. We determine our estimates of contractual adjustments and discounts based on contractual agreements, our discount policies and historical experience. We determine our estimate of implicit price concessions based on our historical collection experience with these classes of patients using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. The financial statement effects of using this practical expedient are not materially different from an individual contract approach.

Gross charges are retail charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately paid and, therefore, are not displayed in our consolidated statements of operations. Hospitals are typically paid amounts that are negotiated with insurance companies or are set by the government. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts (such as stop-loss payments). Because Medicare requires that a hospital's gross charges be the same for all patients (regardless of payer category), gross charges are what hospitals charge all patients prior to the application of discounts and allowances.

Revenues under the traditional fee-for-service ("FFS") Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as Indirect Medical Education, Direct Graduate Medical Education, disproportionate share hospital and bad debt expense reimbursement, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates we record could change by material amounts.

We have a system and estimation process for recording Medicare net patient service revenue and estimated cost report settlements. As a result, we record accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual 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 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 generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and our historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews and investigations.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted FFS rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. We believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for these payers and other factors that affect the estimation process.

We know of no claims, disputes or unsettled matters with any payer that would materially affect our revenues for which we have not adequately provided in the accompanying Consolidated Financial Statements.

Generally, patients who are covered by third-party payers are responsible for related co-pays, co-insurance and deductibles, which vary in amount. We also provide services to uninsured patients and offer uninsured patients a discount from standard charges. We estimate the transaction price for patients with co-pays, co-insurance and deductibles and for those who are uninsured based on historical collection experience and current market conditions. Under our *Compact* and other uninsured discount programs, the discount offered to certain 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 at the time they are recorded through implicit price concessions based on historical collection trends for self-pay accounts and other factors that affect the estimation process. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays, co-insurance amounts and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to net patient service revenues in the period of the change.

We have provided implicit price concessions, primarily to uninsured patients and patients with co-pays, co-insurance and deductibles. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts we expect to collect based on our collection history with similar patients. Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays, co-insurance and deductibles due from patients with insurance, at the time of service while complying with all federal and state statutes and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

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. Patient advocates from Conifer's Medical Eligibility Program 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.

Conifer Revenues—Our Conifer segment recognizes revenue from its contracts when Conifer's performance obligations are satisfied, which is generally as services are rendered. Revenue is recognized in an amount that reflects the consideration to which Conifer expects to be entitled.

At contract inception, Conifer assesses the services specified in its contracts with customers and identifies a performance obligation for each distinct contracted service. Conifer identifies the performance obligations and considers all the services provided under the contract. Conifer generally considers the following distinct services as separate performance obligations:

- revenue cycle management services;
- value-based care services;
- patient communication and engagement services;
- consulting services; and
- other client-defined projects.

Conifer's contracts generally consist of fixed-price, volume-based or contingency-based fees. Conifer's long-term contracts typically provide for Conifer to deliver recurring monthly services over a multi-year period. The contracts are typically priced such that Conifer's monthly fee to its customer represents the value obtained by the customer in the month for those services. Such multi-year service contracts may have upfront fees related to transition or integration work performed by Conifer to set up the delivery for the ongoing services. Such transition or integration work typically does not result in a separately identifiable obligation; thus, the fees and expenses related to such work are deferred and recognized over the life of the related contractual service period. Revenue for fixed-priced contracts is typically recognized at the time of billing unless evidence suggests that the revenue is earned or Conifer's obligations are fulfilled in a different pattern. Revenue for volume-based contracts is typically recognized as the services are being performed at the contractually billable rate, which is generally a percentage of collections or a percentage of client net patient revenue.

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were $2.446 billion and $262 million at December 31, 2020 and 2019, respectively. At December 31, 2020 and 2019, our book overdrafts were $154 million and $246 million, respectively, which were classified as accounts payable.

At December 31, 2020 and 2019, $166 million and $176 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries, and $1 million and $2 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our health plan-related businesses.

At December 31, 2020, 2019 and 2018, we had $93 million, $136 million and $135 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $85 million, $119 million and $114 million, respectively, were included in accounts payable.

During the years ended December 31, 2020, 2019 and 2018, we recorded right-of-use assets related to non-cancellable finance leases of $98 million, $141 million and $149 million, respectively, primarily for equipment.

Investments in Debt and Equity Securities

We classify investments in debt securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. Our policy is to classify investments in debt securities that may be needed for cash requirements as "available-for-sale." At December 31, 2020, we had no significant investments in debt securities classified as either held-to-maturity or trading. We carry debt securities classified as available-for-sale at fair value. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determine that a loss is other-than-temporary, at which point we would record a loss in our consolidated statements of operations.

We carry equity securities at fair value, and we report their unrealized gains and losses in other non-operating expense, net, in our consolidated statements of operations. If the equity security does not have a readily determinable fair value, the carrying value of the security is adjusted only when there is a price change that is observable from a transaction of an identical or similar investment. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Investments in Unconsolidated Affiliates

We control 290 of the facilities within our Ambulatory Care segment and, therefore, consolidate their results. We account for many of the facilities our Ambulatory Care segment operates (106 of 396 at December 31, 2020), as well as additional companies in which our Hospital Operations segment holds ownership interests, under the equity method as investments in unconsolidated affiliates and report only our share of net income as equity in earnings of unconsolidated affiliates in the accompanying Consolidated Statements of Operations. In the year ended December 31, 2020, equity in earnings of unconsolidated affiliates included $17 million from PRF grants recognized by our Ambulatory Care segment's unconsolidated affiliates.

Summarized financial information for these equity method investees is included in the following table; among the equity method investees are four North Texas hospitals in which we held minority interests and that were operated by our Hospital Operations segment through the divestiture of these investments effective March 1, 2018. We recorded a gain of $11 million in the year ended December 31, 2018 due to the sales of our minority interest in these hospitals. For investments acquired during the reported periods, amounts reflect 100% of the investee's results beginning on the date of our acquisition of the investment.

	December 31, 2020	December 31, 2019	December 31, 2018
Current assets	$ 1,309	$ 1,180	$ 842
Noncurrent assets	$ 1,262	$ 1,042	$ 662
Current liabilities	$ (516)	$ (372)	$ (313)
Noncurrent liabilities	$ (866)	$ (739)	$ (430)
Noncontrolling interests	$ (621)	$ (579)	$ (530)

	Years Ended December 31,		
	2020	2019	2018
Net operating revenues	$ 2,665	$ 2,680	$ 2,469
Net income	$ 702	$ 765	$ 599
Net income attributable to the investees	$ 437	$ 499	$ 372

Our equity method investment that contributes the most to our equity in earnings of unconsolidated affiliates is Texas Health Ventures Group, LLC ("THVG"), which is operated by USPI. THVG represented $85 million of the total $169 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2020, $79 million of the total $175 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2019 and $70 million of the total $150 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2018.

Property and Equipment

Additions and improvements to property and equipment exceeding established minimum amounts with a useful life greater than one year are capitalized at cost. Expenditures for maintenance and repairs are charged to expense as incurred. We use the straight-line method of depreciation for buildings, building improvements and equipment. The estimated useful life for buildings and improvements is primarily 15 to 40 years, and for equipment three to 15 years. Newly constructed hospitals are usually depreciated over 50 years. Interest costs related to construction projects are capitalized. In the years ended December 31, 2020, 2019 and 2018, capitalized interest was $5 million, $11 million and $7 million, respectively.

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals or outpatient facilities, depending on their circumstances.

We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Leases

ASU 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Our adoption of ASU 2016-02 was accomplished using a modified retrospective method of application, and our accounting policies related to leases were revised accordingly effective January 1, 2019, as discussed below.

We determine if an arrangement is a lease at inception of the contract. Our right-of-use assets represent our right to use the underlying assets for the lease term and our lease liabilities represent our obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. We use our estimated incremental borrowing rate, which is derived from information available at the lease commencement date, in determining the present value of lease payments. For our Hospital Operations and Conifer segments, we estimate our incremental borrowing rates for our portfolio of leases using documented rates included in our recent equipment finance leases or, if applicable, recent secured debt issuances that correspond to various lease terms. We also give consideration to information obtained from our bankers, our secured debt fair value and publicly available data for instruments with similar characteristics. For our Ambulatory Care segment, we estimate an incremental borrowing rate for each center by utilizing historical and projected financial data, estimating a hypothetical credit rating using publicly available market data and adjusting the market data to reflect the effects of collateralization.

Our operating leases are primarily for real estate, including off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices, as well as medical and office equipment. Our finance leases are primarily for medical equipment and information technology and telecommunications assets. Our real estate lease agreements typically have initial terms of five to 10 years, and our equipment lease agreements typically have initial terms of three years. We do not record leases with an initial term of 12 months or less (“short-term leases”) in our consolidated balance sheets.

Our real estate leases may include one or more options to renew, with renewals that can extend the lease term from five to 10 years. The exercise of lease renewal options is at our sole discretion. In general, we do not consider renewal options to be reasonably likely to be exercised, therefore, renewal options are generally not recognized as part of our right-of-use assets and lease liabilities. Certain leases also include options to purchase the leased property. The useful life of assets and leasehold improvements are limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise. The majority of our medical equipment leases have terms of three years with a bargain purchase option that is reasonably certain of exercise, so these assets are depreciated over their useful life, typically ranging from five to seven years. Similarly, some of our leases of information technology and telecommunications assets include a transfer of title and, therefore, have useful lives of 15 years.

Certain of our lease agreements for real estate include payments based on actual common area maintenance expenses and others include rental payments adjusted periodically for inflation. These variable lease payments are recognized in other operating expenses, net, but are not included in the right-of-use asset or liability balances. Our lease agreements do not contain any material residual value guarantees, restrictions or covenants.

We have elected the practical expedient that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes. We have also elected the practical

expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial indirect costs for existing leases.

Goodwill and Other Intangible Assets

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

Other intangible assets consist of capitalized software costs, which are amortized on a straight-line basis over the estimated useful life of the software, which ranges from three to 15 years, costs of acquired management and other contract service rights, most of which have indefinite lives, and miscellaneous intangible assets.

Income Taxes

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;
- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

Segment Reporting

We primarily operate acute care hospitals and related healthcare facilities. Our Hospital Operations segment generated 81% of our net operating revenues net of implicit price concessions in the years ended December 31, 2020 and 2019, and 80% during the year ended December 31, 2018. At December 31, 2020, each of our markets related to our general hospitals reported directly to our president and chief operating officer. Major decisions, including capital resource allocations, are made at the consolidated level, not at the market or hospital level.

Our Hospital Operations segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. Our Ambulatory Care segment is comprised of the operations of USPI and included Aspen facilities in the United Kingdom until Aspen's divestiture effective August 17, 2018. Our Conifer segment provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

As discussed in Note 5, certain of the facilities were classified as held for sale in the accompanying Consolidated Balance Sheets at December 31, 2020 and 2019.

Costs Associated With Exit or Disposal Activities

We recognize costs associated with exit (including restructuring) or disposal activities when they are incurred and can be measured at fair value, rather than at the date of a commitment to an exit or disposal plan.

NOTE 2. EQUITY

Noncontrolling Interests

Our noncontrolling interests balances at December 31, 2020 and 2019 in the accompanying Consolidated Statements of Changes in Equity were comprised of $116 million and $114 million, respectively, from our Hospital Operations segment, and $793 million and $740 million, respectively, from our Ambulatory Care segment. Our net income attributable to noncontrolling interests for the years ended December 31, 2020, 2019 and 2018 were comprised of $14 million, $16 million and $8 million, respectively, from our Hospital Operations segment, and $169 million, $178 million and $157 million, respectively, from our Ambulatory Care segment.

NOTE 3. ACCOUNTS RECEIVABLE

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

	December 31, 2020	December 31, 2019
Continuing operations:		
Patient accounts receivable	$ 2,499	$ 2,567
Estimated future recoveries	156	162
Net cost reports and settlements receivable and valuation allowances	34	12
	2,689	2,741
Discontinued operations	1	2
Accounts receivable, net	**$ 2,690**	**$ 2,743**

Accounts that are pursued for collection through Conifer's business offices are maintained on our hospitals' books and reflected in patient accounts receivable. Patient accounts receivable, including billed accounts and certain unbilled accounts, as well as estimated amounts due from third-party payers for retroactive adjustments, are receivables if our right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. Estimated uncollectable amounts are generally considered implicit price concessions that are a direct reduction to patient accounts receivable rather than allowance for doubtful accounts.

The following table summarizes the amount and classification of assets and liabilities in the accompanying Consolidated Balance Sheets related to California's provider fee program at December 31, 2020 and 2019:

	December 31, 2020	December 31, 2019
Assets:		
Other current assets	$ 378	$ 316
Investments and other assets	$ 206	$ 213
Liabilities:		
Other current liabilities	$ 110	$ 115
Other long-term liabilities	$ 56	$ 57

We also provide financial assistance through our charity and uninsured discount programs to uninsured patients who are unable to pay for the healthcare services they receive. Our policy is not to pursue collection of amounts determined to qualify for financial assistance; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. These payments are intended to mitigate our cost of uncompensated care. Some states have also developed provider fee or other supplemental payment programs to mitigate the shortfall of Medicaid reimbursement compared to the cost of caring for Medicaid patients.

The following table shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) of caring for our uninsured and charity patients in the years ended December 31, 2020, 2019 and 2018.

	Years Ended December 31,		
	2020	2019	2018
Estimated costs for:			
Uninsured patients	$ 617	$ 664	$ 641
Charity care patients	147	156	124
Total	$ 764	$ 820	$ 765

NOTE 4. CONTRACT BALANCES

Hospital Operations Segment

Amounts related to services provided to patients for which we have not billed and that do not meet the conditions of unconditional right to payment at the end of the reporting period are contract assets. For our Hospital Operations segment, our contract assets include services that we have provided to patients who are still receiving inpatient care in our facilities at the end of the reporting period. Our Hospital Operations segment's contract assets are included in other current assets in the accompanying Consolidated Balance Sheets at December 31, 2020 and 2019. Approximately 89% of our Hospital Operations segment's contract assets meet the conditions for unconditional right to payment and are reclassified to patient receivables within 90 days.

In certain circumstances, when a hospital is experiencing financial difficulty due to delays in receiving payment for the Medicare services it provided, it may be eligible for an accelerated or advance payment pursuant to the Medicare accelerated payment program. As discussed in Note 1, the COVID Acts revised the Medicare accelerated payment program in an attempt to disburse payments to hospitals more quickly to mitigate shortfalls due to delays in non-essential procedures, as well as staffing and billing disruptions. During the year ended December 31, 2020, our Hospital Operations segment received advance payments from the Medicare accelerated payment program following expansion of the program under the COVID Acts. These advance payments are recorded as contract liabilities in the accompanying Consolidated Balance Sheet at December 31, 2020.

The opening and closing balances of contract assets for our Hospital Operations segment are as follows:

	Contract Assets	Contract Liability – Current Advances from Medicare	Contract Liability – Long-term Advances from Medicare
December 31, 2019	$ 170	$ —	$ —
December 31, 2020	208	510	819
Increase	**$ 38**	**$ 510**	**$ 819**
December 31, 2018	$ 169	$ —	$ —
December 31, 2019	170	—	—
Increase	**$ 1**	**$ —**	**$ —**

Ambulatory Care Segment

During the year ended December 31, 2020, our Ambulatory Care segment also received advance payments from the Medicare accelerated payment program following expansion of the program under the COVID Acts. At December 31, 2020, contract liabilities and contract liabilities – long-term in the accompanying Balance Sheet included $51 million and $62 million

of Medicare advance payments received by our unconsolidated affiliates for whom we provide cash management services. The opening and closing balances of contract liabilities for our Ambulatory Care segment are as follows:

	Contract Liability – Current Advances from Medicare	Contract Liability – Long-term Advances from Medicare
December 31, 2019	$ —	$ —
December 31, 2020	93	83
Increase	**$ 93**	**$ 83**
December 31, 2018	$ —	$ —
December 31, 2019	—	—
Increase	**$ —**	**$ —**

Conifer Segment

Conifer enters into contracts with customers to provide revenue cycle management and other services, such as value-based care, consulting and project services. The payment terms and conditions in our customer contracts vary. In some cases, customers are invoiced in advance and (for other than fixed-price fee arrangements) a true-up to the actual fee is included on a subsequent invoice. In other cases, payment is due in arrears. In addition, some contracts contain performance incentives, penalties and other forms of variable consideration. When the timing of Conifer's delivery of services is different from the timing of payments made by the customers, Conifer recognizes either unbilled revenue (performance precedes contractual right to invoice the customer) or deferred revenue (customer payment precedes Conifer service performance). In the following table, customers that prepay prior to obtaining control/benefit of the service are represented by deferred contract revenue until the performance obligations are satisfied. Unbilled revenue represents arrangements in which Conifer has provided services to and the customer has obtained control/benefit of services prior to the contractual invoice date. Contracts with payment in arrears are recognized as receivables in the month the service is performed.

The opening and closing balances of Conifer's receivables, contract asset, and current and long-term contract liabilities are as follows:

	Receivables	Contract Asset – Unbilled Revenue	Contract Liability – Current Deferred Revenue	Contract Liability – Long-Term Deferred Revenue
December 31, 2019	$ 26	$ 11	$ 61	$ 18
December 31, 2020	56	20	56	16
Increase/(decrease)	**$ 30**	**$ 9**	**$ (5)**	**$ (2)**
December 31, 2018	$ 42	$ 11	$ 61	$ 20
December 31, 2019	26	11	61	18
Decrease	**$ (16)**	**$ —**	**$ —**	**$ (2)**

The difference between the opening and closing balances of Conifer's contract assets and contract liabilities are primarily related to prepayments for those customers who are billed in advance, changes in estimates related to metric-based services, and up-front integration services that are typically not distinct and are, therefore, recognized over the performance obligation period to which they relate. Our Conifer segment's receivables and contract assets are reported as part of other current assets in our accompanying Consolidated Balance Sheets, and our Conifer segment's current and long-term contract liabilities are reported as part of contract liabilities and contract liabilities – long-term, respectively, in our accompanying Consolidated Balance Sheets.

In both of the years ended December 31, 2020 and 2019, Conifer recognized $61 million of revenue that was included in the opening current deferred revenue liability. This revenue consists primarily of prepayments for those customers who are billed in advance, changes in estimates related to metric-based services, and up-front integration services that are recognized over the services period.

Contract Costs

We have elected to apply the practical expedient provided by FASB ASC 340-40-25-4 and expense as incurred the incremental customer contract acquisition costs for contracts in which the amortization period of the asset is one year or less. However, incremental costs incurred to obtain and fulfill customer contracts for which the amortization period of the asset is longer than one year, which consist primarily of Conifer deferred contract setup costs, are capitalized and amortized on a straight-line basis over the lesser of their estimated useful lives or the term of the related contract. During the years ended December 31, 2020, 2019 and 2018, we recognized amortization expense of $4 million, $5 million and $11 million, respectively. At December 31, 2020 and 2019, the unamortized customer contract costs were $24 million and $25 million, respectively, and are presented as part of investments and other assets in the accompanying Consolidated Balance Sheets.

NOTE 5. ASSETS AND LIABILITIES HELD FOR SALE

In December 2020, we entered into a definitive agreement to sell the majority of our urgent care centers operated under the MedPost and CareSpot brands from our Hospital Operations and Ambulatory Care segments. As a result, we have classified these assets, totaling $126 million, as “assets held for sale” in current assets and the related liabilities, totaling $70 million, as “liabilities held for sale” in current liabilities in the accompanying Consolidated Balance Sheet at December 31, 2020. We expect to complete the sale of these facilities in the first quarter of 2021.

In the third quarter of 2020, a building we own in the Philadelphia area met the criteria to be classified as held for sale. As a result, we have classified the building and related assets totaling $14 million as “assets held for sale” in current assets in the accompanying Consolidated Balance Sheet at December 31, 2020.

Assets and liabilities classified as held for sale at December 31, 2020 were comprised of the following:

Accounts receivable	$	18
Other current assets		5
Investments and other long-term assets		39
Property and equipment		39
Goodwill		39
Current liabilities		(34)
Long-term liabilities		(36)
Net assets held for sale	**$**	**70**

In the fourth quarter of 2019, we reached a definitive agreement to sell two of our hospitals and other operations in the Memphis area and we classified the related assets and liabilities as held for sale in our consolidated balance sheet at December 31, 2019. Following action by the U.S. Federal Trade Commission to challenge the proposed transaction, we determined in December 2020 that we no longer intend to pursue the sale of the hospitals and related operations. These assets and liabilities were removed from assets and liabilities held for sale and are classified as held and used in the accompanying Consolidated Balance Sheet at December 31, 2020.

In the three months ended March 31, 2019, we completed the sale of three of our hospitals in the Chicago area, as well as other operations affiliated with the hospitals; these assets and liabilities were classified as held for sale beginning in the three months ended December 31, 2017. Related to this transaction, we recorded loss on sale of $5 million and $14 million in the years ended December 31, 2020 and December 31, 2019, respectively, and an impairment charge of $24 million in the year ended December 31, 2018 for the write-down of the assets held for sale to their estimated fair value, less estimated costs to sell.

During the year ended December 31, 2019, we recognized an impairment charge of $26 million for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell, as a result of planned divestitures. No impairment charge was incurred during the year ended December 31, 2020 related to our assets held for sale.

The following table provides information on significant components of our business that have been recently disposed of or are classified as held for sale at December 31, 2020:

	Years Ended December 31,		
	2020	2019	2018
Significant disposals:			
Income (loss) from continuing operations, before income taxes			
Chicago area (includes a $5 million loss on sale in the 2020 period, $14 million loss on sale in the 2019 period, and $24 million of impairment charges in the 2018 period))	$ 3	$ (19)	$ (41)
Total	**$ 3**	**$ (19)**	**$ (41)**

NOTE 6. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

We recognized impairment charges on long-lived assets in 2020, 2019 and 2018 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in healthcare industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

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

At December 31, 2020, our continuing operations consisted of three reportable segments, Hospital Operations, Ambulatory Care and Conifer. Our segments are reporting units used to perform our goodwill impairment analysis. We completed our annual impairment tests for goodwill as of October 1, 2020.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our statement of operations as they are incurred. Our restructuring plans focus on various aspects of operations, including aligning our operations in the most strategic and cost-effective structure, such as the establishment of offshore support operations at our GBC in The Republic of the Philippines that we began in the year ended December 31, 2019. Certain restructuring and acquisition-related costs are based on estimates. Changes in estimates are recognized as they occur.

Year Ended December 31, 2020

During the year ended December 31, 2020, we recorded impairment and restructuring charges and acquisition-related costs of $290 million, consisting of $92 million of impairment charges, $184 million of restructuring charges and $14 million of acquisition-related costs. Impairment charges include $76 million for the write-down of hospital buildings to their estimated fair values in one of our markets, which assets are part of our Hospital Operations segment. Material adverse trends in our recent estimates of future undiscounted cash flows of the hospitals indicated the aggregate 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 included 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 it to the aggregate carrying value of those assets. Because the fair value estimates were lower than the aggregate carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of the hospitals' assets held and used for which impairment charges were recorded was $483 million at December 31, 2020. We also recorded $16 million of other impairment charges. Restructuring charges consisted of $65 million of employee severance costs, $50 million related to the transitioning of various administrative functions to our GBC, $23 million of charges due to the termination of the USPI management equity plan, $14 million of contract and lease termination fees, and $32 million of other restructuring costs. Acquisition-related costs consisted of $14 million of transaction costs. Our impairment charges for the year

ended December 31, 2020 were comprised of $79 million from our Hospital Operations segment, $12 million from our Ambulatory Care segment and $1 million from our Conifer segment.

Year Ended December 31, 2019

During the year ended December 31, 2019, we recorded impairment and restructuring charges and acquisition-related costs of $185 million, consisting of $42 million of impairment charges, $137 million of restructuring charges and $6 million of acquisition-related costs. Impairment charges consisted of $26 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Memphis-area facilities and $16 million of other impairment charges. Of the total impairment charges recognized for the year ended December 31, 2019, $31 million related to our Hospital Operations segment, $6 million related to our Ambulatory Care segment, and $5 million related to our Conifer segment. Restructuring charges consisted of $57 million of employee severance costs, $28 million related to the transitioning of various administrative functions to our GBC, $6 million of contract and lease termination fees, and $46 million of other restructuring costs. Acquisition-related costs consisted of $6 million of transaction costs.

Year Ended December 31, 2018

During the year ended December 31, 2018, we recorded impairment and restructuring charges and acquisition-related costs of $209 million, consisting of $77 million of impairment charges, $115 million of restructuring charges and $17 million of acquisition-related costs. Impairment charges included $40 million for the write-down of buildings and other long-lived assets to their estimated fair values at two hospitals. Material adverse trends in our then 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 included 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. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $130 million at December 31, 2018 after recording the impairment charges. We also recorded $24 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities, $9 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $4 million of other impairment charges. Of the total impairment charges recognized for the year ended December 31, 2018, $67 million related to our Hospital Operations segment, $9 million related to our Ambulatory Care segment, and $1 million related to our Conifer segment. Restructuring charges consisted of $68 million of employee severance costs, $17 million of contract and lease termination fees, and $30 million of other restructuring costs. Acquisition-related costs consisted of $10 million of transaction costs and $7 million of acquisition integration charges.

NOTE 7. LEASES

The following table presents the components of our right-of-use assets and liabilities related to leases and their classification in our Consolidated Balance Sheet at December 31, 2020 and 2019:

Component of Lease Balances	Classification in Consolidated Balance Sheet	December 31, 2020	December 31, 2019
Assets:			
Operating lease assets	Investments and other assets	$ 1,062	$ 912
Finance lease assets	Property and equipment, at cost, less accumulated depreciation and amortization	345	407
Total leased assets		**$ 1,407**	**$ 1,319**
Liabilities:			
Operating lease liabilities:			
Current	Other current liabilities	$ 188	$ 159
Long-term	Other long-term liabilities	999	858
Total operating lease liabilities		1,187	1,017
Finance lease liabilities:			
Current	Current portion of long-term debt	122	143
Long-term	Long-term debt, net of current portion	151	182
Total finance lease liabilities		273	325
Total lease liabilities		**$ 1,460**	**$ 1,342**

The following table presents the components of our lease expense and their classification in our Consolidated Statement of Operations for the years ended December 31:

Component of Lease Expense	Classification on Consolidated Statements of Operations	2020	2019
Operating lease expense	Other operating expenses, net	$ 247	$ 211
Finance lease expense:			
Amortization of leased assets	Depreciation and amortization	86	85
Interest on lease liabilities	Interest expense	11	15
Total finance lease expense		97	100
Variable and short term-lease expense	Other operating expenses, net	156	133
Total lease expense		**$ 500**	**$ 444**

Rental expense under operating leases, including short-term leases, was $326 million in the year ended December 31, 2018. Included in rental expense for the year ended December 31, 2018 was sublease income of $11 million, which was recorded as a reduction of rental expense.

The weighted-average lease terms and discount rates for operating and finance leases are presented in the following table for the years ended December 31:

	2020	2019
Weighted-average remaining lease term (years)		
Operating leases	7.9	7.8
Finance leases	5.7	5.4
Weighted-average discount rate		
Operating leases	5.5 %	5.6 %
Finance leases	5.6 %	5.5 %

Cash flow and other information related to leases is included in the following table years ended December 31:

	2020	2019
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash outflows from operating leases	$ 239	$ 197
Operating cash outflows from finance leases	$ 15	$ 18
Financing cash outflows from finance leases	$ 154	$ 151
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 304	$ 249
Finance leases	$ 98	$ 141

Future maturities of lease liabilities at December 31, 2020 are presented in the following table:

	Operating Leases	Finance Leases	Total
2021	$ 231	$ 133	$ 364
2022	212	73	285
2023	191	29	220
2024	168	11	179
2025	141	9	150
Later years	544	87	631
Total lease payments	1,487	342	1,829
Less: Imputed interest	300	69	369
Total lease obligations	1,187	273	1,460
Less: Current obligations	188	122	310
Long-term lease obligations	**$ 999**	**$ 151**	**$ 1,150**

In December 2020, we completed the sale and leaseback of a medical office building located in Hialeah, FL. The sale generated net proceeds of $60 million and a gain of $19 million, which is reflected in other operating expenses in the

accompanying Consolidated Statements of Operations at December 31, 2020. The lease agreement for the medical office building is for a period of 12 years and includes four sequential renewal options, each for a period of five years.

NOTE 8. LONG-TERM DEBT

The table below shows our long-term debt as of December 31, 2020 and 2019:

	December 31, 2020	December 31, 2019
Senior unsecured notes:		
8.125% due 2022	$ —	$ 2,800
6.750% due 2023	1,872	1,872
7.000% due 2025	478	478
6.125% due 2028	2,500	—
6.875% due 2031	362	362
Senior secured first lien notes:		
4.625% due 2024	1,870	1,870
4.625% due 2024	600	600
7.500% due 2025	700	—
4.875% due 2026	2,100	2,100
5.125% due 2027	1,500	1,500
4.625% due 2028	600	—
Senior secured second lien notes:		
5.125% due 2025	1,410	1,410
6.250% due 2027	1,500	1,500
Finance leases, mortgage and other notes	403	445
Unamortized issue costs and note discounts	(176)	(186)
Total long-term debt	**15,719**	**14,751**
Less current portion	145	171
Long-term debt, net of current portion	**$ 15,574**	**$ 14,580**

Credit Agreement

We have a senior secured revolving credit facility that provides for revolving loans in an aggregate principal amount of up to $1.9 billion with a $200 million subfacility for standby letters of credit. We amended our credit agreement (as amended, the "Credit Agreement") in April 2020 to, among other things, (i) increase the aggregate revolving credit commitments from the previous limit of $1.5 billion to $1.9 billion, subject to borrowing availability, and (ii) increase the advance rate and raise limits on certain eligible accounts receivable in the calculation of the borrowing base, in each case, for an incremental period of 364 days (the "incremental period"). At December 31, 2020, we had no cash borrowings outstanding under the Credit Agreement, and we had less than $1 million of standby letters of credit outstanding. Based on our eligible receivables, $1.9 billion was available for borrowing under the revolving credit facility at December 31, 2020.

The Credit Agreement continues to have a scheduled maturity date of September 12, 2024, and obligations under the Credit Agreement continue to be guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and secured by a first-priority lien on the eligible inventory and accounts receivable owned by us and the subsidiary guarantors, including receivables for Medicaid supplemental payments.

Outstanding revolving loans accrued interest during a one-month initial period following the April 2020 amendment at the rate of either (i) a base rate plus a margin of 0.75% per annum or (ii) the London Interbank Offered Rate ("LIBOR") plus a margin of 1.75% per annum. Thereafter, outstanding revolving loans accrue interest at either (i) a base rate plus a margin ranging from 0.50% to 1.00% per annum during the incremental period and 0.25% to 0.75% per annum thereafter, or (ii) LIBOR plus a margin ranging from 1.50% to 2.00% per annum during the incremental period and 1.25% to 1.75% per annum thereafter, in each case based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.25% to 0.375% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible inventory and accounts receivable, including self-pay accounts.

Letter of Credit Facility

In March 2020, we amended our letter of credit facility (as amended, the "LC Facility") to extend the scheduled maturity date of the LC Facility from March 7, 2021 to September 12, 2024 and to increase the aggregate principal amount of standby and documentary letters of credit that from time to time may be issued thereunder from $180 million to $200 million. On July 29, 2020, we further amended the LC Facility to increase the maximum secured debt covenant from 4.00 to 1.00 on a quarterly basis up to 6.00 to 1.00 for the quarter ending March 31, 2021, which maximum ratio will step down on a quarterly basis through the quarter ending December 31, 2021. Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes.

Drawings under any letter of credit issued under the LC Facility that we have not reimbursed within three business days after notice thereof accrue interest at a base rate plus a margin of 0.50% per annum. An unused commitment fee is payable at an initial rate of 0.25% per annum with a step up to 0.375% per annum should our secured debt-to-EBITDA ratio equal or exceed 3.00 to 1.00 at the end of any fiscal quarter. A fee on the aggregate outstanding amount of issued but undrawn letters of credit accrues at a rate of 1.50% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At December 31, 2020, we were in compliance with all covenants and conditions in our LC Facility. At December 31, 2020, we had $88 million of standby letters of credit outstanding under the LC Facility.

Senior Secured Notes and Senior Unsecured Notes

On September 16, 2020, we sold $2.5 billion aggregate principal amount of 6.125% senior notes, which will mature on October 1, 2028 (the "2028 Senior Notes"). We will pay interest on the 2028 Senior Notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2021. The proceeds from the sale of the 2028 Senior Notes were used, after payment of fees and expenses, together with cash on hand, to finance the redemption of all $2.556 billion aggregate principal amount then outstanding of our 8.125% senior unsecured notes due 2022 (the "2022 Senior Notes") for approximately $2.843 billion. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $305 million in the three months ended September 30, 2020, primarily related to the difference between the purchase price and the par value of the 2022 Senior Notes, as well as the write-off of associated unamortized issuance costs.

In August and July 2020, we purchased approximately $109 million aggregate principal amount of our 2022 Senior Notes for approximately $114 million. In connection with the purchases, we recorded losses from early extinguishment of debt totaling $7 million in the three months ended September 30, 2020, primarily related to the differences between the purchase prices and the par values of the 2022 Senior Notes, as well as the write-offs of associated unamortized issuance costs.

In June 2020, we purchased approximately $135 million aggregate principal amount of our 2022 Senior Notes for approximately $142 million. In connection with the purchase, we recorded a loss from early extinguishment of debt of approximately $8 million in the three months ended June 30, 2020, primarily related to the difference between the purchase price and the par value of the 2022 Senior Notes, as well as the write-off of associated unamortized issuance costs.

On June 16, 2020, we sold $600 million aggregate principal amount of 4.625% senior secured first lien notes, which will mature on June 15, 2028 (the "2028 Senior Secured First Lien Notes"). We will pay interest on the 2028 Senior Secured First Lien Notes semi-annually in arrears on June 15 and December 15 of each year, which payments commenced on December 15, 2020.

On April 7, 2020, we sold $700 million aggregate principal amount of 7.500% senior secured first lien notes, which will mature on April 1, 2025 (the "2025 Senior Secured First Lien Notes"). We will pay interest on the 2025 Senior Secured First Lien Notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2020. A portion of the proceeds from the sale of the 2025 Senior Secured First Lien Notes was used, after payment of fees and expenses, to repay the $500 million aggregate principal amount of borrowings outstanding under our Credit Agreement as of March 31, 2020.

On August 26, 2019, we sold $600 million aggregate principal amount of 4.625% senior secured first lien notes, which will mature on September 1, 2024 (the "2024 Senior Secured First Lien Notes"), $2.1 billion aggregate principal amount of 4.875% senior secured first lien notes, which will mature on January 1, 2026 (the "2026 Senior Secured First Lien Notes") and $1.5 billion aggregate principal amount of 5.125% senior secured first lien notes, which will mature on November 1, 2027 (the "2027 Senior Secured First Lien Notes"). We will pay interest on the 2024 Senior Secured First Lien Notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on March 1, 2020. We will pay interest on the

2026 Senior Secured First Lien Notes semi-annually in arrears on January 1 and July 1 of each year, which payments commenced on January 1, 2020. We will pay interest on the 2027 Senior Secured First Lien Notes semi-annually in arrears on May 1 and November 1 of each year, which payments commenced on May 1, 2020. The proceeds from the sales of these notes were used, after payment of fees and expenses, together with cash on hand and borrowings under our senior secured revolving credit facility, to fund the redemptions of all $500 million aggregate principal amount of our outstanding 4.750% senior secured first lien notes due 2020, all $1.8 billion aggregate principal amount of our outstanding 6.000% senior secured first lien notes due 2020, all $850 million aggregate principal amount of our outstanding 4.500% senior secured first lien notes due 2021 and all $1.05 billion aggregate principal amount of our outstanding 4.375% senior secured first lien notes due 2021. In connection with the redemptions, we recorded a loss from early extinguishment of debt of approximately $180 million in the three months ended September 30, 2019, primarily related to the difference between the redemption prices and the par values of the notes, as well as the write-off of the associated unamortized issuance costs.

On February 5, 2019, we sold $1.5 billion aggregate principal amount of 6.250% senior secured second lien notes, which will mature on February 1, 2027 (the "2027 Senior Secured Second Lien Notes"). We will pay interest on the 2027 Senior Secured Second Lien Notes semi-annually in arrears on February 1 and August 1 of each year, which payments commenced on August 1, 2019. The proceeds from the sale of the 2027 Senior Secured Second Lien Notes were used, after payment of fees and expenses, together with cash on hand and borrowings under our senior secured revolving credit facility, to fund the redemption of all $300 million aggregate principal amount of our outstanding 6.750% senior notes due 2020 and all $750 million aggregate principal amount of our outstanding 7.500% senior secured second lien notes due 2022, as well as the repayment upon maturity of all $468 million aggregate principal amount of our outstanding 5.500% senior unsecured notes due March 1, 2019. In connection with the redemptions, we recorded a loss from early extinguishment of debt of approximately $47 million in the three months ended March 31, 2019, primarily related to the difference between the redemption prices and the par values of the notes, as well as the write-off of the associated unamortized issuance costs.

All of our senior secured notes are guaranteed by certain of our wholly owned domestic hospital company subsidiaries and secured by a pledge of the capital stock and other ownership interests of those subsidiaries on either a first lien or second lien basis, as indicated in the table above. All of our senior secured notes and the related subsidiary guarantees are our and the subsidiary guarantors' senior secured obligations. All of our senior secured notes rank equally in right of payment with all of our other senior secured indebtedness. Our senior secured notes rank senior to any subordinated indebtedness that we or such subsidiary guarantors may incur; they are effectively senior to our and such subsidiary guarantors' existing and future unsecured indebtedness and other liabilities to the extent of the value of the collateral securing the notes and the subsidiary guarantees; they are effectively subordinated to our and such subsidiary guarantors' obligations under our Credit Agreement to the extent of the value of the collateral securing borrowings thereunder; and they are structurally subordinated to all obligations of our non-guarantor subsidiaries.

The indentures setting forth the terms of our senior secured notes contain provisions governing our ability to redeem the notes and the terms by which we may do so. At our option, we may redeem our senior secured notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed plus the make-whole premium set forth in the related indenture, together with accrued and unpaid interest thereon, if any, to the redemption date. Certain series of the senior secured notes may also be redeemed, in whole or in part, at certain redemption prices set forth in the applicable indentures, together with accrued and unpaid interest. In addition, we may be required to purchase for cash all or any part of each series of our senior secured notes upon the occurrence of a change of control (as defined in the applicable indentures) for a cash purchase price of 101% of the aggregate principal amount of the notes, plus accrued and unpaid interest.

All of our senior unsecured notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to our senior secured notes described above, the obligations of our subsidiaries and any obligations under our Credit Agreement to the extent of the value of the collateral. We may redeem any series of our senior unsecured notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed, plus a make-whole premium specified in the applicable indenture, if any, together with accrued and unpaid interest to the redemption date.

Covenants

Credit Agreement. Our Credit Agreement contains customary covenants for an asset-backed facility, including a minimum fixed charge coverage ratio to be met if the designated excess availability under the revolving credit facility falls below $150 million, as well as limits on debt, asset sales and prepayments of certain other debt. The Credit Agreement also includes a provision, which we believe is customary in receivables-backed credit facilities, that gives our lenders the right to require that proceeds of collections of substantially all of our consolidated accounts receivable be applied directly to repay outstanding loans and other amounts that are due and payable under the Credit Agreement at any time that unused borrowing

availability under the revolving credit facility is less than $150 million for three consecutive business days or if an event of default has occurred and is continuing thereunder. In that event, we would seek to re-borrow under the Credit Agreement to satisfy our operating cash requirements. Our ability to borrow under the Credit Agreement is subject to conditions that we believe are customary in revolving credit facilities, including that no events of default then exist.

Senior Secured Notes. The indentures governing our senior secured notes contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions or consolidate, merge or sell all or substantially all of our or their assets, other than in certain transactions between one or more of our wholly owned subsidiaries. These restrictions, however, are subject to a number of exceptions and qualifications. In particular, there are no restrictions on our ability or the ability of our subsidiaries to incur additional indebtedness, make restricted payments, pay dividends or make distributions in respect of capital stock, purchase or redeem capital stock, enter into transactions with affiliates or make advances to, or invest in, other entities (including unaffiliated entities). In addition, the indentures governing our senior secured notes contain a covenant that neither we nor any of our subsidiaries will incur secured debt, unless at the time of and after giving effect to the incurrence of such debt, the aggregate amount of all such secured debt (including the aggregate principal amount of senior secured notes outstanding and any outstanding borrowings under our Credit Agreement at such time) does not exceed the amount that would cause the secured debt ratio (as defined in the indentures) to exceed 4.0 to 1.0.

Senior Unsecured Notes. The indentures governing our senior unsecured notes contain covenants and conditions that have, among other requirements, limitations on (1) liens on "principal properties" and (2) sale and lease-back transactions with respect to principal properties. A principal property is defined in the senior unsecured notes indentures as a hospital that has an asset value on our books in excess of 5% of our consolidated net tangible assets, as defined in such indentures. The above limitations do not apply, however, to (1) debt that is not secured by principal properties or (2) debt that is secured by principal properties if the aggregate of such secured debt does not exceed 15% of our consolidated net tangible assets, as further described in the indentures. The senior unsecured notes indentures also prohibit the consolidation, merger or sale of all or substantially all assets unless no event of default would result after giving effect to such transaction.

Future Maturities

Future long-term debt maturities, including finance lease obligations, as of December 31, 2020 are as follows:

		Years Ending December 31,					
	Total	**2021**	**2022**	**2023**	**2024**	**2025**	**Later Years**
Long-term debt, including finance lease obligations	$ 15,895	$ 145	$ 100	$ 1,925	$ 2,494	$ 2,607	$ 8,624

NOTE 9. GUARANTEES

Consistent with our policy on physician relocation and recruitment, we provide income guarantee agreements to certain physicians who agree to relocate to fill a community need in the service area of one of our hospitals and commit to remain in practice in the area for a specified period of time. Under such agreements, we are required to make payments to the physicians in excess of the amounts they earn in their practices up to the amount of the income guarantee. The income guarantee periods are typically 12 months. If a physician does not fulfill his or her commitment period to the community, which is typically three years subsequent to the guarantee period, we seek recovery of the income guarantee payments from the physician on a prorated basis. We also provide revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals with terms generally ranging from one to three years.

At December 31, 2020, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $145 million. We had a total liability of $114 million recorded for these guarantees included in other current liabilities at December 31, 2020.

At December 31, 2020, we also had issued guarantees of the indebtedness and other obligations of our investees to third parties, the maximum potential amount of future payments under which was approximately $77 million. Of the total, $10 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Consolidated Balance Sheet at December 31, 2020.

NOTE 10. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

We have granted options and restricted stock units to certain of our employees and directors pursuant to our stock incentive plans. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock in the future, and the fair value of the restricted stock unit is based on our share price on the grant date. Typically, options and time-based restricted stock units vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have different vesting terms. In addition, restricted stock unit grants we make to our non-employee directors as part of their annual compensation vest immediately and are settled on the third anniversary of the date of grant, while initial grants to directors vest immediately but settle upon separation from the board.

We also grant performance-based options and performance-based restricted stock units that vest subject to the achievement of specified performance goals within a specified time frame. These awards generally vest and are settled on the third anniversary of the grant date with payouts ranging from 0% to 200% of the target value depending upon the level of achievement. For certain of our performance-based awards, the number of options or restricted stock units that ultimately vest is subject to adjustment based on the achievement of a market-based condition. The fair value of these awards is estimated using a discrete model to analyze the fair value of the subject shares. The discrete model utilizes multiple stock paths, through the use of a Monte Carlo simulation, which paths are then analyzed to determine the fair value of the subject shares.

At December 31, 2020, assuming outstanding performance-based restricted stock units and options for which performance has not yet been determined will achieve target performance, approximately 6.2 million shares of common stock were available under our 2019 Stock Incentive Plan for future stock option grants and other equity incentive awards, including restricted stock units. The accompanying Consolidated Statements of Operations for the years ended December 31, 2020, 2019 and 2018 include $44 million, $42 million and $46 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements.

The table below shows certain stock option and restricted stock unit grants and other awards that comprise the stock-based compensation expense recorded in the year ended December 31, 2020. Compensation cost is measured by the fair value of the awards on their grant dates and is recognized over the requisite service period of the awards, whether or not the awards had any intrinsic value during the period.

Grant Date	Awards	Exercise Price Per Share	Fair Value Per Share at Grant Date	Stock-Based Compensation Expense for Year Ended December 31, 2020
	(In Thousands)			(In Millions)
Stock Options:				
February 27, 2019	188	$ 28.26	$ 12.49	$ 1
February 28, 2018	398	$ 20.60	$ 8.83	1
Restricted Stock Units:				
May 29, 2020	103		$ 15.71	2
February 26, 2020	1,038		$ 27.80	9
January 19, 2020	24		$ 37.14	1
February 27, 2019	790		$ 28.26	9
January 31, 2019	318		$ 21.99	2
March 29, 2018	293		$ 24.25	1
February 28, 2018	160		$ 20.60	1
Other grants				5
USPI Management Equity Plan	2,025		$ 34.13	12
				$ 44

Pursuant to the terms of our stock-based compensation plans, awards granted under the plan vest and may be exercised as determined by the human resources committee of our board of directors. In the event of a change in control, the human resources committee of our board of directors may, at its sole discretion without obtaining shareholder approval, accelerate the vesting or performance periods of the awards.

Stock Options

The following table summarizes stock option activity during the years ended December 31, 2020, 2019 and 2018:

	Options	Wtd. Avg. Exercise Price Per Share	Aggregate Intrinsic Value	Wtd. Avg Remaining Life
			(In Millions)	
Outstanding at December 31, 2017	2,564,822	$ 20.35		
Granted	635,196	21.33		
Exercised	(619,849)	18.19		
Forfeited/Expired	(317,426)	35.30		
Outstanding at December 31, 2018	2,262,743	$ 19.12		
Granted	230,713	28.28		
Exercised	(306,427)	18.05		
Forfeited/Expired	(226,037)	20.21		
Outstanding at December 31, 2019	1,960,992	$ 20.24		
Exercised	(987,471)	17.96		
Forfeited/Expired	(60,990)	23.28		
Outstanding at December 31, 2020	**912,531**	**$ 22.51**	**$ 16**	**6.4 years**
Vested and expected to vest at December 31, 2020	**912,531**	**$ 22.51**	**$ 16**	**6.4 years**
Exercisable at December 31, 2020	**282,652**	**$ 19.80**	**$ 6**	**5.6 years**

There were 987,471 stock options exercised during the year ended December 31, 2020 with an aggregated intrinsic value of approximately $15 million, and 306,427 stock options exercised in 2019 with an aggregate intrinsic value of approximately $3 million.

There were no performance-based stock options granted in the year ended December 31, 2020, and 230,713 performance-based stock options granted in the year ended 2019. On March 29, 2019, we granted an aggregate of 7,862 performance-based stock options to a senior officer. The options will all vest on the third anniversary of the grant date because, in the three months ended March 31, 2020, the requirement that our stock close at a price of at least $36.05 (a 25% premium above the March 29, 2019 grant-date closing stock price of $28.84) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date. On February 27, 2019, we granted to certain of our senior officers an aggregate of 222,851 performance-based stock options. The options will all vest on the third anniversary of the grant date because, in the three months ended March 31, 2020, the requirement that our stock close at a price of at least $35.33 (a 25% premium above the February 27, 2019 grant-date closing stock price of $28.26) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date.

At December 31, 2020, there were $1 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 1.0 years.

The weighted average estimated fair value of stock options we granted during the year ended December 31, 2019 was $12.50 per share. These fair values were calculated based on each grant date, using a Monte Carlo simulation with the following assumptions:

	February 27, 2019
Expected volatility	48%
Expected dividend yield	0%
Expected life	6.2 years
Expected forfeiture rate	0%
Risk-free interest rate	2.53%

The expected volatility used for the 2019 Monte Carlo simulations incorporates historical volatility based on an analysis of historical prices of our stock. The expected volatility reflects the historical volatility for a duration consistent with the expected life of the options; it does not consider the implied volatility from open-market exchanged options due to the limited trading activity and the transient nature of factors impacting our stock price volatility. The historical share-price volatility for 2019 excludes the movements in our stock price for the period from August 15, 2017 through November 30, 2017 due to impact that the announcement of the departure of certain board members and officers, as well as reports that we were

exploring a potential sale of the company, had on our stock price during that time. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise time frames.

The following table summarizes information about our outstanding stock options at December 31, 2020:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Wtd. Avg. Remaining Contractual Life	Wtd. Avg. Exercise Price	Number of Options	Wtd. Avg. Exercise Price
$16.43 to $19.759	245,152	6.2 years	$ 18.99	245,152	$ 18.99
$19.76 to $35.430	667,379	6.5 years	23.80	37,500	25.08
	912,531	**6.4 years**	**$ 22.51**	**282,652**	**$ 19.80**

As of December 31, 2020, 68.8% of all our outstanding options were held by current employees and 31.2% were held by former employees. Of our outstanding options, 100% were in-the-money, that is, they had exercise price less than the $39.93 market price of our common stock on December 31, 2020.

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	628,046	68.8 %	—	— %	628,046	68.8 %
Former employees	284,485	31.2 %	—	— %	284,485	31.2 %
Totals	**912,531**	**100.0 %**	**—**	**— %**	**912,531**	**100.0 %**
% of all outstanding options	**100.0 %**		**— %**		**100.0 %**	

Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2020, 2019 and 2018:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2017	2,253,988	$ 35.20
Granted	765,184	24.74
Vested	(995,331)	32.63
Forfeited	(139,711)	36.01
Unvested at December 31, 2018	1,884,130	$ 32.25
Granted	1,481,021	27.87
Vested	(1,562,191)	36.45
Forfeited	(339,461)	24.74
Unvested at December 31, 2019	1,463,499	$ 25.08
Granted	1,767,730	27.72
Vested	(825,727)	25.66
Forfeited	(310,296)	32.09
Unvested at December 31, 2020	**2,095,206**	**$ 25.87**

In the year ended December 31, 2020, we granted an aggregate of 1,767,730 restricted stock units. Of these, 607,198 will vest and be settled ratably over a three-year period from the grant date, 104,167 will vest and be settled ratably over a four-year period from the grant date, 359,713 will vest and be settled ratably over 11 quarterly periods from the grant date, and 13,805 will vest and be settled on the third anniversary of the grant date. The vesting of 579,413 performance-based restricted stock units we granted in 2020 is contingent on our achievement of specified performance goals for the years 2020 to 2023. In addition, in May 2020, we made an annual grant of 103,434 restricted stock units to our non-employee directors for the 2020-2021 board service year.

In the year ended December 31, 2019, we granted an aggregate of 1,481,021 restricted stock units. Of these, 337,848 will vest and be settled ratably over a three-year period from the grant date, 566,172 will vest and be settled ratably over nine quarterly periods from the grant date, and 353,354 will vest and be settled on the third anniversary of the grant date. In addition, in May 2019, we made an annual grant of 100,444 restricted stock units to our non-employee directors for the 2019-2020 board service year, which units vested immediately and will settle in shares of our common stock on the third anniversary of the date of the grant. The board of directors appointed two new members, one in August 2019 and one in October 2019. We made initial grants totaling 5,569 restricted stock units to these directors, as well as prorated annual grants totaling 13,257 restricted stock units. Both the initial grants and the annual grants vested immediately, however, the initial

grants settle upon separation from the board, while the annual grants settle on the third anniversary of the grant date. We also granted 7,427 additional restricted stock units that vested and settled immediately as a result of our level of achievement with respect to a performance goal on a 2013 grant and 96,950 additional restricted stock units as a result of our level of achievement with respect to a performance goal on 2014 grants.

As of December 31, 2020, there were $31 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 1.7 years.

USPI Management Equity Plan

2015 USPI Management Equity Plan

In 2015, USPI adopted the USPI Holding Company, Inc. 2015 Stock Incentive Plan ("2015 USPI Management Equity Plan") under which it granted non-qualified options to purchase nonvoting shares of USPI's outstanding common stock to eligible plan participants, allowing the recipient to participate in incremental growth in the value of USPI from the applicable grant date. Under the 2015 USPI Management Equity Plan, the total pool of options consisted of approximately 10% of USPI's fully diluted outstanding common stock. Options had an exercise price equal to the estimated fair market value of USPI's common stock on the date of grant. The option awards were structured such that they had a three or four year vesting period in which half of the award vested in equal pro-rata amounts over the applicable vesting period and the remaining half vested at the end of the applicable three or four year period. Any unvested awards were forfeited upon the participant's termination of service with USPI, and vested options were required to have been exercised within 90 days of termination. Once an award was exercised and the requisite holding period met, the participant was eligible to sell the underlying shares to USPI at their estimated fair market value. Payment for USPI's purchase of any eligible nonvoting common shares could be made in cash or in shares of Tenet's common stock.

In February 2020, the 2015 USPI Management Equity Plan and all unvested options granted under the plan were terminated in accordance with the terms of the plan. USPI repurchased all vested options and all shares of USPI stock acquired upon exercise of an option for approximately $35 million.

2020 USPI Management Equity Plan

In February 2020, USPI adopted the USPI Holding Company, Inc. Restricted Stock Plan ("2020 USPI Management Equity Plan") to replace the terminated 2015 USPI Management Equity Plan. Restricted stock units granted under the plan generally vest 20% in each of the first three years on the anniversary of the grant date with the remaining 40% vesting on the fourth anniversary of the grant date. Once the requisite holding period is met, during specified times the participant can sell the underlying shares to USPI at their estimated fair market value. At our sole discretion, the purchase of any non-voting common shares can be made in cash or in shares of Tenet's common stock.

During the year ended December 31, 2020, USPI granted 2,556,353 shares of restricted non-voting common stock to eligible plan participants under the new plan. At December 31, 2020, 2,025,056 shares of restricted stock units were outstanding, all of which are expected to vest. The first vesting of these shares, which includes 382,550 shares, is expected to occur in February 2021.

The accompanying Consolidated Statement of Operations for the years ended December 2020, 2019 and 2018 includes $12 million, $11 million and $18 million, respectively, of pre-tax compensation costs related to USPI's management equity plans.

Employee Stock Purchase Plan

We have an employee stock purchase plan under which we are currently authorized to issue up to 4,070,363 shares of common stock to our eligible employees. As of December 31, 2020, there were approximately 2.8 million shares available for issuance under our employee stock purchase plan. Under the terms of the plan, eligible employees may elect to have between 1% and 10% of their base earnings withheld each quarter to purchase shares of our common stock. Shares are purchased at a price equal to 95% of the closing price on the last day of the quarter. The plan requires a one-year holding period for all shares issued. The holding period does not apply upon termination of employment. Under the plan, no individual may purchase, in any year, shares with a fair market value in excess of $25,000. The plan is currently not considered to be compensatory.

We issued the following numbers of shares under our employee stock purchase plan in the years ended December 31, 2020, 2019 and 2018:

	Years Ended December 31,		
	2020	2019	2018
Number of shares	254,767	215,422	228,045
Weighted average price	$ 19.97	$ 24.44	$ 22.96

Employee Retirement Plans

Substantially all of our employees, upon qualification, are eligible to participate in one of our defined contribution 401(k) plans. Under the plans, employees may contribute a portion of their eligible compensation, which we may match with employer contributions at our discretion. Employer matching contributions will vary by plan. Plan expenses, primarily related to our contributions to the plans, were $119 million, $127 million and $99 million for the years ended December 31, 2020, 2019 and 2018, respectively. Such amounts are reflected in salaries, wages and benefits in the accompanying Consolidated Statements of Operations.

We maintain three frozen non-qualified defined benefit pension plans ("SERPs") that provide supplemental retirement benefits to certain of our current and former executives. These plans are not funded, and plan obligations for these plans are paid from our working capital. Pension benefits are generally based on years of service and compensation. Upon completing the acquisition of Vanguard Health Systems, Inc. on October 1, 2013, we assumed a frozen qualified defined benefit plan ("DMC Pension Plan") covering substantially all of the employees of our Detroit market that were hired prior to June 1, 2003. The benefits paid under the DMC Pension Plan are primarily based on years of service and final average earnings. During the year ended December 31, 2019, the Society of Actuaries issued a new mortality base table (Pri-2012), which we incorporated into the estimates of our defined benefit plan obligations beginning December 31, 2019. During the years ended December 31, 2020 and 2019, the Society of Actuaries issued new mortality improvement scales (MP-2020 and MP-2019, respectively), which we incorporated into the estimates of our defined benefit plan obligations at December 31, 2020 and 2019. These changes to our mortality assumptions decreased our projected benefit obligations as of December 31, 2020 and 2019 by approximately $39 million and $14 million, respectively.

The following tables summarize the balance sheet impact, as well as the benefit obligations, funded status and rate assumptions associated with the SERPs and the DMC Pension Plan based on actuarial valuations prepared as of December 31, 2020 and 2019:

	December 31,	
	2020	2019
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations[1]		
Beginning obligations	$ (1,369)	$ (1,301)
Interest cost	(47)	(58)
Actuarial loss	(92)	(132)
Benefits paid	79	123
Special termination benefit costs	—	(1)
Ending obligations	(1,429)	(1,369)
Fair value of plans assets		
Beginning plan assets	790	731
Gain on plan assets	98	128
Employer contribution	38	33
Benefits paid	(57)	(102)
Ending plan assets	869	790
Funded status of plans	$ (560)	$ (579)
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (63)	$ (19)
Other long-term liability	$ (497)	$ (560)
Accumulated other comprehensive loss	$ 355	$ 323
SERP Assumptions:		
Discount rate	2.75 %	3.50 %
Compensation increase rate	3.00 %	3.00 %
Measurement date	December 31, 2020	December 31, 2019
DMC Pension Plan Assumptions:		
Discount rate	2.53 %	3.60 %
Compensation increase rate	Frozen	Frozen
Measurement date	December 31, 2020	December 31, 2019

(1) The accumulated benefit obligation at December 31, 2020 and 2019 was approximately $1.426 billion and $1.367 billion, respectively.

The components of net periodic benefit costs and related assumptions are as follows:

	Years Ended December 31,		
	2020	2019	2018
Service costs	$ —	$ —	$ 2
Interest costs	47	58	56
Expected return on plan assets	(48)	(46)	(54)
Amortization of net actuarial loss	9	10	14
Special termination benefit costs	—	1	—
Net periodic benefit cost	$ 8	$ 23	$ 18
SERP Assumptions:			
Discount rate	3.50 %	4.50 %	3.75 %
Long-term rate of return on assets	n/a	n/a	n/a
Compensation increase rate	3.00 %	3.00 %	3.00 %
Measurement date	January 1, 2020	January 1, 2019	January 1, 2018
Census date	January 1, 2020	January 1, 2019	January 1, 2018
DMC Pension Plan Assumptions:			
Discount rate	3.60 %	4.62 %	4.00 %
Long-term rate of return on assets	6.25 %	6.50 %	6.50 %
Compensation increase rate	Frozen	Frozen	Frozen
Measurement date	January 1, 2020	January 1, 2019	January 1, 2018
Census date	January 1, 2020	January 1, 2019	January 1, 2018

Net periodic benefit costs for the current year are based on assumptions determined at the valuation date of the prior year for the SERPs and the DMC Pension Plan.

We recorded loss adjustments of $32 million, $42 million and $15 million in other comprehensive income (loss) in the years ended December 31, 2020, 2019 and 2018, respectively, to recognize changes in the funded status of our SERPs and the DMC Pension Plan. Changes in the funded status are recorded as a direct increase or decrease to shareholders' equity through accumulated other comprehensive loss. Net actuarial losses of $41 million, $52 million and $29 million were recognized during the years ended December 31, 2020, 2019 and 2018, respectively, and the amortization of net actuarial loss of $9 million, $10 million and $14 million for the years ended December 31, 2020, 2019 and 2018, respectively, were recognized in other comprehensive income (loss). Actuarial gains (losses) affecting the benefit obligation during the years ended December 31, 2020, 2019 and 2018 are primarily attributable to changes in the discount rate utilized for the SERP and DMC Pension Plan. Cumulative net actuarial losses of $355 million, $323 million and $281 million as of December 31, 2020, 2019 and 2018, respectively, and unrecognized prior service costs of less than $1 million as of each of the years ended December 31, 2019 and 2018 have not yet been recognized as components of net periodic benefit cost. There were no unrecognized prior service costs at December 31, 2020.

To develop the expected long-term rate of return on plan assets assumption, the DMC Pension Plan considers the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns on each asset class. The expected return for each asset class is then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. The weighted-average asset allocations by asset category as of December 31, 2020, were as follows:

Asset Category	Target	Actual
Cash and cash equivalents	— %	5 %
Equity securities	46 %	56 %
Debt securities	39 %	36 %
Alternative investments	15 %	3 %

The DMC Pension Plan assets are invested in separately managed portfolios using investment management firms. The objective for all asset categories is to maximize total return without assuming undue risk exposure. The DMC Pension Plan maintains a well-diversified asset allocation that meets these objectives. The DMC Pension Plan assets are largely comprised of equity securities, which include companies with various market capitalization sizes in addition to international and convertible securities. Cash and cash equivalents are comprised of money market funds and repurchase agreements secured by U.S. Treasury or federal agency obligations. Debt securities include domestic and foreign government obligations, corporate bonds, and mortgage-backed securities. Alternative investments is a broadly defined asset category with the objective of diversifying the portfolio, complementing traditional equity and fixed income securities and improving the overall performance consistency of the portfolio. Alternative investments may include, but are not limited to, diversified fund of hedge funds in the form of professionally-managed pooled limited partnership investments and investments in private markets.

In each investment account, the DMC Pension Plan investment managers are responsible for monitoring and reacting to economic indicators, such as gross domestic product, consumer price index and U.S. monetary policy that may affect the performance of their account. The performance of all managers and the aggregate asset allocation are formally reviewed on a quarterly basis. The current asset allocation objective is to maintain a certain percentage with each class allowing for a deviation from the target ranging from 2.5% for alternative investments to 5.0% for fixed income investments, with a rebalancing of the asset allocation occurring when the portfolio exceeds the permissible deviation range.

The following tables summarize the DMC Pension Plan assets measured at fair value on a recurring basis as of December 31, 2020 and 2019, aggregated by the level in the fair value hierarchy within which those measurements are determined. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices for similar assets, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

	December 31, 2020	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 44	$ 44	$ —	$ —
Equity securities	484	484	—	—
Debt Securities:				
U.S. government obligations	76	76	—	—
Corporate debt securities	240	240	—	—
Alternative investments:				
Private equity securities	8	—	—	8
Hedge funds	17	—	17	—
	$ 869	$ 844	$ 17	$ 8

	December 31, 2019	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 37	$ 37	$ —	$ —
U.S. government obligations	9	9	—	—
Equity securities	461	461	—	—
Fixed income funds	283	283	—	—
	$ 790	$ 790	$ —	$ —

The following table presents the estimated future benefit payments to be made from the SERPs and the DMC Pension Plan, a portion of which will be funded from plan assets, for the next five years and in the aggregate for the five years thereafter:

		Years Ending December 31,					Five Years
	Total	2021	2022	2023	2024	2025	Thereafter
Estimated benefit payments	$ 845	$ 83	$ 85	$ 86	$ 86	$ 86	$ 419

The SERP and DMC Pension Plan obligations of $560 million at December 31, 2020 are classified in the accompanying Consolidated Balance Sheet as an other current liability of $63 million and defined benefit plan obligations of $497 million based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately $63 million for the year ending December 31, 2021.

NOTE 11. PROPERTY AND EQUIPMENT

The principal components of property and equipment are shown in the table below:

	December 31,	
	2020	2019
Land	$ 612	$ 602
Buildings and improvements	6,985	6,856
Construction in progress	33	184
Equipment	4,593	4,173
Finance lease assets	512	561
	12,735	12,376
Accumulated depreciation and amortization	(6,043)	(5,498)
Net property and equipment	**$ 6,692**	**$ 6,878**

Property and equipment is stated at cost, less accumulated depreciation and amortization and impairment write-downs related to assets held and used.

NOTE 12. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying Consolidated Balance Sheets as of 2020 and 2019:

	2020	2019
Hospital Operations		
As of January 1:		
Goodwill	$ 5,338	$ 5,410
Accumulated impairment losses	(2,430)	(2,430)
Total	2,908	2,980
Goodwill acquired during the year and purchase price allocation adjustments	—	—
Goodwill related to assets held for sale and disposed or deconsolidated facilities	37	(72)
Total	**$ 2,945**	**$ 2,908**
As of December 31:		
Goodwill	$ 5,375	$ 5,338
Accumulated impairment losses	(2,430)	(2,430)
Total	**$ 2,945**	**$ 2,908**

	2020	2019
Ambulatory Care		
As of January 1:		
Goodwill	$ 3,739	$ 3,696
Accumulated impairment losses	—	—
Total	3,739	3,696
Goodwill acquired during the year and purchase price allocation adjustments	1,581	43
Goodwill related to assets held for sale and disposed or deconsolidated facilities	(62)	—
Total	**$ 5,258**	**$ 3,739**
As of December 31:		
Goodwill	$ 5,258	$ 3,739
Accumulated impairment losses	—	—
Total	**$ 5,258**	**$ 3,739**

	2020	2019
Conifer		
As of January 1:		
Goodwill	$ 605	$ 605
Accumulated impairment losses	—	—
Total	605	605
Goodwill acquired during the year and purchase price allocation adjustments	—	—
Total	**$ 605**	**$ 605**
As of December 31:		
Goodwill	$ 605	$ 605
Accumulated impairment losses	—	—
Total	**$ 605**	**$ 605**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of 2020 and 2019:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2020:			
Capitalized software costs	$ 1,800	$ (1,084)	$ 716
Trade names	102	—	102
Contracts	872	(111)	761
Other	110	(89)	21
Total	**$ 2,884**	**$ (1,284)**	**$ 1,600**
At December 31, 2019:			
Capitalized software costs	$ 1,616	$ (912)	$ 704
Trade names	102	—	102
Contracts	869	(94)	775
Other	107	(86)	21
Total	**$ 2,694**	**$ (1,092)**	**$ 1,602**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2020 is as follows:

		Years Ending December 31,					
	Total	2021	2022	2023	2024	2025	Later Years
Amortization of intangible assets	$ 917	$ 158	$ 126	$ 112	$ 95	$ 82	$ 344

We recognized amortization expense of $172 million, $188 million and $185 million in the accompanying Consolidated Statements of Operations for the years ended December 31, 2020, 2019 and 2018, respectively.

NOTE 13. INVESTMENTS AND OTHER ASSETS

The principal components of investments and other assets in the accompanying Consolidated Balance Sheets are as follows:

	December 31,	
	2020	2019
Marketable securities	$ 3	$ 2
Equity investments in unconsolidated healthcare entities	1,024	978
Total investments	1,027	980
Cash surrender value of life insurance policies	42	36
Long-term deposits	67	59
California provider fee program receivables	206	213
Operating lease assets	1,062	912
Land held for expansion, other long-term receivables and other assets	130	169
Investments and other assets	**$ 2,534**	**$ 2,369**

NOTE 14. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

	December 31,	
	2020	2019
Adjustments for defined benefit plans	$ (281)	$ (257)
Accumulated other comprehensive loss	**$ (281)**	**$ (257)**

The income tax benefits allocated to the adjustments for our defined benefit plans was approximately $7 million and $8 million for the year ended December 31, 2020 and 2019, respectively.

NOTE 15. NET OPERATING REVENUES

Net operating revenues for our Hospital Operations and Ambulatory Care segments primarily consist of net patient service revenues, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact* and other uninsured discount and charity programs. Net operating revenues for our Conifer segment primarily consist of revenues from providing revenue cycle management services to health systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

The table below shows our sources of net operating revenues less implicit price concessions from continuing operations:

	Years Ended December 31,		
	2020	2019	2018
Hospital Operations:			
Net patient service revenues from hospitals and related outpatient facilities:			
Medicare	$ 2,695	$ 2,888	$ 2,882
Medicaid	1,081	1,193	1,294
Managed care	9,022	9,516	9,213
Uninsured	162	92	96
Indemnity and other	658	679	596
Total	13,618	14,368	14,081
Other revenues[1]	1,172	1,154	1,204
Hospital Operations total prior to inter-segment eliminations	**14,790**	**15,522**	**15,285**
Ambulatory Care	**2,072**	**2,158**	**2,085**
Conifer	**1,306**	**1,372**	**1,533**
Inter-segment eliminations	**(528)**	**(573)**	**(590)**
Net operating revenues	**$ 17,640**	**$ 18,479**	**$ 18,313**

(1) Primarily physician practices revenues.

Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2020, 2019 and 2018 by $6 million, $27 million and $24 million, respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Consolidated Balance Sheets (see Note 3). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

The table below shows the composition of net operating revenues for our Ambulatory Care segment:

	Years Ended December 31,		
	2020	2019	2018
Net patient service revenues	$ 1,960	$ 2,040	$ 1,965
Management fees	86	95	92
Revenue from other sources	26	23	28
Net operating revenues	**$ 2,072**	**$ 2,158**	**$ 2,085**

The table below shows the composition of net operating revenues for our Conifer segment:

	Years Ended December 31,		
	2020	2019	2018
Revenue cycle services – Tenet	$ 514	$ 556	$ 568
Revenue cycle services – other customers	700	713	855
Other services – Tenet	14	17	22
Other services – other customers	78	86	88
Net operating revenues	**$ 1,306**	**$ 1,372**	**$ 1,533**

Other services represented approximately 7% of Conifer's revenue for the year ended December 31, 2020 and include value-based care services, consulting services and other client-defined projects.

Performance Obligations

The following table includes Conifer's revenue that is expected to be recognized in the future related to performance obligations that are unsatisfied, or partially unsatisfied, at the end of the reporting period. The amounts in the table primarily consist of revenue cycle management fixed fees, which are typically recognized ratably as the performance obligation is satisfied. The estimated revenue does not include volume- or contingency-based contracts, performance incentives, penalties or other variable consideration that is considered constrained. Conifer's contract with Catholic Health Initiatives ("CHI"), a minority interest owner of Conifer Health Solutions, LLC, represents the majority of the fixed-fee revenue related to remaining performance obligations. Conifer's contract term with CHI ends December 31, 2032.

		Years Ending December 31,					
	Total	2021	2022	2023	2024	2025	Later Years
Performance obligations	$ 6,650	$ 594	$ 593	$ 593	$ 541	$ 541	$ 3,788

NOTE 16. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy period April 1, 2020 through March 31, 2021, we have coverage totaling $850 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million for floods, $200 million for earthquakes and a per-occurrence sub-limit of $200 million for named windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and named windstorms, the total $850 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $40 million for California earthquakes, $25 million for floods and named windstorms, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Floods and certain other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Reserves

We are self-insured for the majority of our professional and general liability claims and purchase insurance from third-parties to cover catastrophic claims. At December 31, 2020 and 2019, the aggregate current and long-term professional and general liability reserves in the accompanying Consolidated Balance Sheets were $978 million and $965 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. As described in Note 1, in the three months ended March 31, 2020, we changed our method of accounting for our estimated professional and general liability claims, as well as other claims-related liabilities. Under the new method of accounting, the liabilities are reported on an undiscounted basis whereas, previously, the liabilities were reported on a discounted basis.

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

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of $320 million, $356 million and $399 million for the years ended December 31, 2020, 2019 and 2018, respectively, of which $120 million, $155 million and $176 million, respectively, related to adverse claims development for prior years.

NOTE 17. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. We and our subsidiaries have received inquiries in recent years from government agencies, and we may receive similar inquiries in future periods. We are also subject to class action lawsuits, employment-related claims and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. Significant judgment is required in both the determination of the probability of a loss and the determination as to whether a loss is reasonably estimable. These determinations are updated at least quarterly and are adjusted to reflect the effects of negotiations, settlements, rulings, advice of legal counsel and technical experts, and other information and events pertaining to a particular matter, but are subject to significant uncertainty regarding numerous factors that could affect the ultimate loss levels. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information. Given the inherent uncertainties associated with these matters, especially those involving governmental agencies, and the indeterminate damages sought in some cases, there is significant uncertainty as to the ultimate liability we may incur from these matters, and an adverse outcome in one or more of these matters could be material to our results of operations or cash flows for any particular reporting period.

Oklahoma Surgical Hospital Qui Tam Action

In July 2020, certain of the parties to a previously disclosed qui tam lawsuit filed under seal in May 2016 in the Western District of Oklahoma entered into a settlement agreement with the U.S. Department of Justice ("DOJ") to resolve the matter. The parties to the settlement agreement include (i) Oklahoma Center for Orthopaedic & Multispecialty Surgery ("OCOM"), a surgical hospital jointly owned by USPI, a health system partner and physicians, (ii) Southwest Orthopaedic Specialists, an independent physician practice group, and (iii) USPI. Also in July 2020, OCOM entered into a corporate integrity agreement with the Office of Inspector General of HHS. USPI and Tenet are not parties to OCOM's corporate integrity agreement.

As previously reported, an agreement in principle was reached with the DOJ in October 2019 to resolve the qui tam lawsuit and related investigations against USPI and OCOM for approximately $66 million, subject at that time to further approvals by the DOJ and other government agencies. In the three months ended September 30, 2019, we established a reserve of $68 million for this matter, which included an estimate of the relator's attorney's fees and certain other costs to be paid by USPI. In the three months ended December 31, 2019, we increased the reserve for this matter by an additional $1 million to reflect updated information on the other costs to be paid by USPI. In addition, in the year ended December 31, 2020, we increased the reserve for this matter by less than $1 million to reflect updated information with respect to the relator's anticipated attorney's fees and other costs. USPI paid the full settlement amount in July 2020, and the claims in the qui tam lawsuit against OCOM, USPI, Tenet and their affiliated entities, among others, were dismissed in August 2020. We paid the relator's attorney's fees and other costs in November 2020, which fully resolved this matter.

Government Investigation of Detroit Medical Center

Detroit Medical Center ("DMC") is subject to an ongoing civil investigation commenced in October 2017 by the U.S. Attorney's Office for the Eastern District of Michigan and the Civil Division of the DOJ for potential violations of the Stark law, the Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act, and the federal False Claims Act related to DMC's employment of nurse practitioners and physician assistants ("Mid-Level Practitioners") from 2006 through 2017. As previously disclosed, a media report was published in August 2017 alleging that 14 Mid-Level Practitioners were terminated by DMC earlier in 2017 due to compliance concerns. We are cooperating with the investigation; however, we are unable to determine the potential exposure, if any, at this time.

Other Matters

In July 2019, certain of the entities that purchased the operations of Hahnemann University Hospital and St. Christopher's Hospital for Children in Philadelphia from us commenced Chapter 11 bankruptcy proceedings. As previously disclosed in our Form 8-K filed September 1, 2017, the purchasers assumed our funding obligations under the Pension Fund for Hospital and Health Care Employees of Philadelphia and Vicinity (the "Fund"), a pension plan related to the operations at Hahnemann University Hospital and, pursuant to rules under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), under certain circumstances we could become liable for withdrawal liability in the event a withdrawal is triggered with respect to the Fund. In addition, pursuant to applicable ERISA rules, we could become secondarily liable if the purchasers fail to satisfy their obligations to the Fund.

We are also subject to claims and lawsuits arising in the ordinary course of business, including potential claims related to, among other things, the care and treatment provided at our hospitals and outpatient facilities, the application of various federal and state labor laws, tax audits and other matters. Although the results of these claims and lawsuits cannot be predicted

with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material effect on our business or financial condition.

New claims or inquiries may be initiated against us from time to time, including lawsuits from patients, employees and others exposed to COVID-19 at our facilities. These matters could (1) require us to pay substantial damages or amounts in judgments or settlements, which, individually or in the aggregate, could exceed amounts, if any, that may be recovered under our insurance policies where coverage applies and is available, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) cause us to close or sell hospitals or otherwise modify the way we conduct business.

The following table presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded in continuing operations during the years ended December 31, 2020, 2019 and 2018. No amounts were recorded in discontinued operations in those years.

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2020	$ 86	$ 44	$ (108)	$ 4	$ 26
Year Ended December 31, 2019	$ 8	$ 141	$ (55)	$ (8)	$ 86
Year Ended December 31, 2018	$ 12	$ 38	$ (41)	$ (1)	$ 8

For the years ended December 31, 2020, 2019 and 2018, we recorded net costs of $44 million, $141 million and $38 million, respectively, in connection with significant legal proceedings and governmental investigations. The costs in the 2019 period include $69 million of accruals for the now-resolved OCOM matter described above.

NOTE 18. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

As part of the formation of USPI in 2015, we entered into a put/call agreement with respect to the equity interests in USPI held by our joint venture partners at that time. During 2016, 2017 and 2018, we paid a total of $1.473 billion to purchase additional shares of USPI to increase our ownership interest in USPI from 50.1% to 95%.

In addition, we entered into a separate put call agreement (the "Baylor Put/Call Agreement") with Baylor University Medical Center ("Baylor") that contains put and call options with respect to the 5% ownership interest in USPI held by Baylor. Each year starting in 2021, Baylor may put up to one-third of their total shares in USPI held as of April 1, 2017 by delivering notice by the end of January of such year. In each year that Baylor does not put the full 33.3% of USPI's shares allowable, we may call the difference between the number of shares Baylor put and the maximum number of shares they could have put that year. Baylor did not deliver a put notice to us in January 2021. 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. Based on the nature of the Baylor Put/Call Agreement, Baylor's minority interest in USPI was classified as a redeemable noncontrolling interest in the accompanying Consolidated Balance Sheets at December 31, 2020 and 2019.

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the years ended 2020 and 2019:

	December 31,	
	2020	2019
Balances at beginning of period	**$ 1,506**	**$ 1,420**
Net income	186	192
Distributions paid to noncontrolling interests	(135)	(145)
Accretion of redeemable noncontrolling interests	4	18
Purchases and sales of businesses and noncontrolling interests, net	391	21
Balances at end of period	**$ 1,952**	**$ 1,506**

Our redeemable noncontrolling interests balances at December 31, 2020 and 2019 in the table above were comprised of $267 million and $383 million, respectively, from our Hospital Operations segment, $1.273 billion and $777 million, respectively, from our Ambulatory Care segment, and $412 million and $346 million, respectively, from our Conifer segment. Our net income attributable to redeemable noncontrolling interests for the years ended December 31, 2020 and 2019 in the accompanying Consolidated Statements of Operations included losses of $33 million and $37 million, respectively, from our

Hospital Operations segment, income of $153 million and $159 million, respectively, from our Ambulatory Care segment, and income of $66 million and $70 million, respectively, from our Conifer segment.

NOTE 19. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2020, 2019 and 2018 consists of the following:

	Years Ended December 31,		
	2020	2019	2018
Current tax expense (benefit):			
Federal	$ —	$ (6)	$ (6)
State	30	26	33
	30	20	27
Deferred tax expense (benefit):			
Federal	(131)	140	156
State	4	—	(10)
	(127)	140	146
	$ (97)	**$ 160**	**$ 173**

A reconciliation between the amount of reported income tax expense (benefit) and the amount computed by multiplying income from continuing operations before income taxes by the statutory federal income tax rate is shown below. State income tax expense for the year ended December 31, 2020 includes $1 million of expense related to the write-off of expired or worthless unutilized state net operating loss carryforwards and other deferred tax assets for which a full valuation allowance had been provided in prior years. A corresponding tax benefit of $1 million is included for the year ended December 31, 2020 to reflect the reduction in the valuation allowance. Foreign pre-tax loss was $13 million for the year ended December 31, 2020, and $6 million for the years ended December 31, 2019 and 2018.

	Years Ended December 31,		
	2020	2019	2018
Tax expense at statutory federal rate of 21%	$ 141	$ 67	$ 132
State income taxes, net of federal income tax benefit	33	21	23
Expired state net operating losses, net of federal income tax benefit	1	2	9
Tax attributable to noncontrolling interests	(75)	(79)	(70)
Nondeductible goodwill	—	4	8
Nondeductible executive compensation	6	6	4
Nondeductible litigation costs	—	7	—
Expired charitable contribution carryforward	1	8	—
Impact of decrease in federal tax rate on deferred taxes	—	—	(1)
Reversal of permanent reinvestment assumption and other adjustments related to divestiture of foreign subsidiary	—	—	(6)
Stock-based compensation tax deficiencies (benefits)	(2)	4	5
Changes in valuation allowance (including impact of decrease in federal tax rate)	(226)	133	76
Change in tax contingency reserves, including interest	—	(14)	(1)
Prior-year provision to return adjustments and other changes in deferred taxes	14	(3)	(5)
Other items	10	4	(1)
Income tax expense (benefit)	**$ (97)**	**$ 160**	**$ 173**

The CARES Act includes a significant number of tax provisions applicable to individuals and businesses. For businesses, the CARES Act makes changes to the U.S. tax code relating to, among other things: (1) the business interest expense disallowance rules for 2019 and 2020; (2) net operating loss rules; (3) charitable contribution limitations; and (4) the realization of corporate alternative minimum tax credits. As a result of the change in the business interest expense disallowance rules, we recorded an income tax benefit of $88 million during the year ended December 31, 2020 to decrease the valuation allowance for interest expense carryforwards due to the additional deduction of interest expense.

In September 2020, we filed an application with the Internal Revenue Service (“IRS”) to change our method of accounting for certain capitalized costs on our 2019 tax return. This change in tax accounting method resulted in additional interest expense being allowed on the 2019 and 2020 tax returns. We reduced our valuation allowance by an additional $126 million in the year ended December 31, 2020 related to the change in accounting method.

Deferred income taxes reflect the tax effects of temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amount used for income tax purposes. The following table discloses those significant components of our deferred tax assets and liabilities, including any valuation allowance:

	December 31, 2020		December 31, 2019	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ —	$ 621	$ —	$ 282
Reserves related to discontinued operations and restructuring charges	8	—	14	—
Receivables (doubtful accounts and adjustments)	173	—	165	—
Accruals for retained insurance risks	223	—	209	—
Intangible assets	—	385	—	356
Other long-term liabilities	55	—	35	—
Benefit plans	265	—	274	—
Other accrued liabilities	74	—	45	—
Investments and other assets	—	73	—	95
Interest expense limitation	8	—	219	—
Net operating loss carryforwards	566	—	179	—
Stock-based compensation	11	—	19	—
Right-of-use lease assets and obligations	224	224	—	—
Other items	86	39	45	34
	1,693	**1,342**	**1,204**	**767**
Valuation allowance	(55)	—	(281)	—
	$ 1,638	**$ 1,342**	**$ 923**	**$ 767**

Below is a reconciliation of the deferred tax assets and liabilities and the corresponding amounts reported in the accompanying Consolidated Balance Sheets.

	December 31,	
	2020	2019
Deferred income tax assets	$ 325	$ 183
Deferred tax liabilities	(29)	(27)
Net deferred tax asset	**$ 296**	**$ 156**

During the year ended December 31, 2020, the valuation allowance decreased by $226 million, including a decrease of $211 million due to limitations on the tax deductibility of interest expense, a decrease of $1 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and a decrease of $14 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2020 was $55 million. During the year ended December 31, 2019, the valuation allowance increased by $133 million, including an increase of $130 million due to limitations on the tax deductibility of interest expense, a decrease of $2 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and an increase of $5 million due to changes in expected realizability of deferred tax assets. The remaining balance in the valuation allowance at December 31, 2019 was $281 million. During the year ended December 31, 2018, the valuation allowance decreased by $76 million, including an increase of $89 million due to limitations on deductions of interest expense, a decrease of $9 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and a decrease of $4 million due to changes in expected realizability of deferred tax assets. The remaining balance in the valuation allowance as of December 31, 2018 was $148 million. Deferred tax assets relating to interest expense limitations under Internal Revenue Code Section 163(j) have a full valuation allowance because the interest expense carryovers are not expected to be utilized in the foreseeable future.

We account for uncertain tax positions in accordance with FASB ASC 740-10-25, which prescribes a comprehensive model for the financial statement recognition, measurement, presentation and disclosure of uncertain tax positions taken or expected to be taken in income tax returns. The following table summarizes the total changes in unrecognized tax benefits in continuing operations during the years ended December 31, 2020, 2019 and 2018. There were no such changes in discontinued operations. The additions and reductions for tax positions include the impact of items for which the ultimate deductibility is highly certain, but for which there is uncertainty about the timing of such deductions. Such amounts include unrecognized tax benefits that have impacted deferred tax assets and liabilities at December 31, 2020, 2019 and 2018.

	Continuing Operations
Balance At December 31, 2017	**$ 46**
Reductions due to a lapse of statute of limitations	(1)
Balance At December 31, 2018	**$ 45**
Reductions due to a lapse of statute of limitations	(14)
Balance At December 31, 2019	**$ 31**
Reductions due to a lapse of statute of limitations	—
Balance At December 31, 2020	**$ 31**

The total amount of unrecognized tax benefits as of December 31, 2020 was $31 million, of which $29 million, if recognized, would affect our effective tax rate and income tax benefit from continuing operations. In the year ended December 31, 2020, there was no change in our estimated liabilities for uncertain tax positions. The total amount of unrecognized tax benefits as of December 31, 2019 was $31 million, of which $29 million, if recognized, would affect our effective tax rate and income tax expense from continuing operations. Income tax expense in the year ended December 31, 2019 includes a benefit of $11 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2018 was $45 million, of which $43 million, if recognized, would affect our effective tax rate and income tax expense from continuing operations. Income tax expense in the year ended December 31, 2018 includes a benefit of $1 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. We did not have any interest or penalties on unrecognized tax benefits accrued at December 31, 2020.

The IRS has completed audits of our tax returns for all tax years ended on or before December 31, 2007. All disputed issues with respect to these audits have been resolved and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007 and USPI's tax returns for years ended after December 31, 2016 remain subject to audit by the IRS.

As of December 31, 2020, no significant changes in unrecognized federal and state tax benefits are expected in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

At December 31, 2020, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $2.367 billion pre-tax, $1.126 billion of which expires in 2021 to 2034 and $1.241 billion of which has no expiration date, (2) general business credit carryforwards of approximately $25 million expiring in 2023 through 2039, (3) charitable contribution carryforwards of approximately $195 million expiring in 2021 through 2025 and (4) state NOL carryforwards of approximately $3.728 billion expiring in 2021 through 2040 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $61 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs, the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

NOTE 20. EARNINGS (LOSS) PER COMMON SHARE

The following table is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for our continuing operations for the years ended December 31, 2020, 2019 and 2018. Net income available (loss attributable) to our common shareholders is expressed in millions and weighted average shares are expressed in thousands.

	Net Income Available (Loss Attributable) to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Year Ended December 31, 2020			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 399	105,010	$ 3.80
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	1,253	(0.05)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 399**	**106,263**	**$ 3.75**
Year Ended December 31, 2019			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (226)	103,398	$ (2.19)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	**$ (226)**	**103,398**	**$ (2.19)**
Year Ended December 31, 2018			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 101	102,110	$ 0.99
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	1,771	(0.02)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 101**	**103,881**	**$ 0.97**

In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. For this reason, all potentially dilutive securities were excluded from the calculation of diluted loss per share for the year ended December 31, 2019. Had we generated income from continuing operations available to common shareholders in the year ended December 31, 2019, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 1,457 for the year ended December 31, 2019.

NOTE 21. FAIR VALUE MEASUREMENTS

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

The following tables disclose the assets measured at fair value on a non-recurring basis as of December 31, 2020 and 2019:

	December 31, 2020	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held for sale	$ 140	$ —	$ 140	$ —
Long-lived assets held and used	483	—	483	—
	$ 623	$ —	$ 623	$ —

	December 31, 2019	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held for sale	$ 387	$ —	$ 387	$ —

There were zero liabilities measured at fair value on a non-recurring basis as of December 31, 2020 and 2019.

As discussed in Note 6, we recognized an impairment charge of $76 million to write down buildings in one of our Hospital Operations segment's markets to their estimated fair value.

In the year ended December 31, 2019, we recorded impairment charges in continuing operations of $26 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Memphis-area facilities.

Financial Instruments

The fair value of our long-term debt (except for borrowings under the Credit Agreement) is based on quoted market prices (Level 1). The inputs used to establish the fair value of the borrowings outstanding under the Credit Agreement are considered to be Level 2 inputs, which include inputs other than quoted prices included in Level 1 that are observable, either directly or indirectly. At December 31, 2020 and 2019, the estimated fair value of our long-term debt was approximately 104.5% and 106.4%, respectively, of the carrying value of the debt.

NOTE 22. ACQUISITIONS

In December 2020, USPI acquired controlling interests in 45 ASCs (collectively, the "SCD Centers") from SurgCenter Development and physician owners. The fair value of the consideration conveyed (the "purchase price") for the SCD Centers was $1.115 billion, consisting of a cash payment of $1.097 billion, fully funded using cash on hand, and the assumption of $18 million of center-level debt.

In addition to the SCD Centers, we acquired ownership interests in 10 outpatient businesses (all of which are in our Ambulatory Care segment), and various physician practices during the year ended December 31, 2020. The aggregate purchase price for these acquisitions was $80 million.

During the year ended December 31, 2019, we acquired ownership interests in 10 outpatient businesses (all of which are in our Ambulatory Care segment), three off-campus emergency departments and various physician practices. The aggregate purchase price for the acquisitions was $25 million.

During the year ended December 31, 2018, we acquired ownership interests in 10 outpatient businesses (all of which are in our Ambulatory Care segment) and various physician practices. The aggregate purchase price for the acquisitions was $113 million.

We are required to allocate the purchase prices of acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocated over those fair values is recorded as goodwill. The purchase price allocations for certain acquisitions completed in 2020, including the SCD Centers, is preliminary. We are in process of assessing working capital balances as well as obtaining and evaluating valuations of the acquired property and equipment, management contracts and other intangible assets, and noncontrolling interests. Therefore,

those purchase price allocations, including goodwill, recorded in the accompanying consolidated financial statements are subject to adjustment once the assessments and valuation work are completed and evaluated. Such adjustments will be recorded as soon as practical and within the measurement period as defined by the accounting literature.

Preliminary or final purchase price allocations for all the acquisitions made during the years ended December 31, 2020, 2019 and 2018 are as follows:

	2020	2019	2018
Current assets	$ 67	$ 16	$ 6
Property and equipment	63	20	19
Other intangible assets	14	4	9
Goodwill	1,581	43	220
Other long-term assets, including previously held equity method investments	38	24	(18)
Current liabilities	(45)	(16)	—
Long-term liabilities	(43)	(35)	(15)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(478)	(18)	(21)
Noncontrolling interests	(20)	(7)	(85)
Cash paid, net of cash acquired	(1,177)	(25)	(113)
Gains on consolidations	**$ —**	**$ 6**	**$ 2**

The goodwill generated from these transactions, the majority of which will be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. The goodwill total of $1.581 billion from acquisitions completed during the year ended December 31, 2020 was recorded in our Ambulatory Care segment. Approximately $14 million, $6 million and $10 million in transaction costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2020, 2019 and 2018, respectively, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Consolidated Statements of Operations.

During the years ended December 31, 2019 and 2018, we recognized gains totaling $6 million and $2 million, respectively, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

Pro Forma Information - Unaudited

The following table provides certain pro forma information for Tenet as if the SCD Centers acquisition had occurred at the beginning of the year ended December 31, 2019.

	Year Ended December 31,	
	2020	2019
Net operating revenues	$ 18,034	$ 18,910
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ 470	$ (131)
Diluted earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders	$ 4.42	$ (1.27)

NOTE 23. SEGMENT INFORMATION

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

Our Hospital Operations segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. As described in Note 5, certain of these facilities were classified as held for sale in the accompanying Consolidated Balance Sheets at December 31, 2020 and 2019. At December 31, 2020, our subsidiaries operated 65 hospitals serving primarily urban and suburban communities in nine states.

Our Ambulatory Care segment is comprised of the operations of USPI and included Aspen facilities in the United Kingdom until their divestiture effective August 17, 2018. At December 31, 2020, USPI had interests in 308 ASCs, 40 urgent care centers operated under the CareSpot brand, 24 imaging centers and 24 surgical hospitals in 31 states. As described

in Note 5, certain of these facilities were classified as held for sale in the accompanying Consolidated Balance Sheet at December 31, 2020. At December 31, 2020, we owned 95% of USPI.

Our Conifer segment provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients. At December 31, 2020, Conifer provided services to approximately 630 Tenet and non-Tenet hospitals and other clients nationwide. In 2012, we entered into agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations 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. At December 31, 2020, we owned 76.2% of Conifer Health Solutions, LLC, which is the principal subsidiary of Conifer Holdings, Inc.

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

	December 31, 2020	December 31, 2019	December 31, 2018
Assets:			
Hospital Operations	$ 18,048	$ 16,196	$ 15,705
Ambulatory Care	8,048	6,195	5,711
Conifer	1,010	974	1,014
Total	**$ 27,106**	**$ 23,365**	**$ 22,430**

	Years Ended December 31,		
	2020	2019	2018
Capital expenditures:			
Hospital Operations	$ 467	$ 572	$ 527
Ambulatory Care	51	75	68
Conifer	22	23	22
Total	**$ 540**	**$ 670**	**$ 617**
Net operating revenues:			
Hospital Operations total prior to inter-segment eliminations	$ 14,790	$ 15,522	$ 15,285
Ambulatory Care	2,072	2,158	2,085
Conifer			
Tenet	528	573	590
Other clients	778	799	943
Total Conifer revenues	1,306	1,372	1,533
Inter-segment eliminations	(528)	(573)	(590)
Total	**$ 17,640**	**$ 18,479**	**$ 18,313**
Equity in earnings of unconsolidated affiliates:			
Hospital Operations	$ 6	$ 15	$ 10
Ambulatory Care	163	160	140
Total	**$ 169**	**$ 175**	**$ 150**
Adjusted EBITDA:			
Hospital Operations	$ 1,911	$ 1,449	$ 1,401
Ambulatory Care	868	895	792
Conifer	367	386	357
Total	**$ 3,146**	**$ 2,730**	**$ 2,550**
Depreciation and amortization:			
Hospital Operations	$ 739	$ 733	$ 685
Ambulatory Care	81	72	68
Conifer	37	45	49
Total	**$ 857**	**$ 850**	**$ 802**

	Years Ended December 31,		
	2020	2019	2018
Adjusted EBITDA	**$ 3,146**	**$ 2,730**	**$ 2,550**
Income (loss) from divested and closed businesses	20	(2)	9
Depreciation and amortization	(857)	(850)	(802)
Impairment and restructuring charges, and acquisition-related costs	(290)	(185)	(209)
Litigation and investigation costs	(44)	(141)	(38)
Interest expense	(1,003)	(985)	(1,004)
Gain (loss) from early extinguishment of debt	(316)	(227)	1
Other non-operating income (expense), net	1	(5)	(5)
Net gains (losses) on sales, consolidation and deconsolidation of facilities	14	(15)	127
Income from continuing operations, before income taxes	**$ 671**	**$ 320**	**$ 629**

NOTE 24. RECENT ACCOUNTING STANDARDS

Recently Issued Accounting Standards

In August 2018, the FASB issued ASU 2018-14, "Compensation – Retirement Benefits – Defined Benefit Plans –General (Subtopic 715-20) Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans" ("ASU 2018-14"), which applies to all employers that sponsor defined benefit pension or other postretirement plans. The amendments in ASU 2018-14, which remove, modify or add certain disclosure requirements as part of the FASB's disclosure framework project to improve the effectiveness of the notes to the financial statements, are effective for us beginning in 2021. The adoption of this guidance will not impact our financial position, results of operations or cash flows.

Recently Adopted Accounting Standards

Effective January 1, 2020, as further discussed in Note 1, we adopted ASU 2016-13 using the modified retrospective transition approach as of the period of adoption. Also effective January 1, 2020, we adopted ASU 2018-13, "Fair Value Measurement (Topic 820) Disclosure Framework – Changes to the Disclosure Framework Requirements for Fair Value Measurement" ("ASU 2018-13") using the prescribed transition method and ASU 2018-15, "Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40) Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That is a Service Contract" ("ASU 2018-15") using the prospective transition method. The adoption of ASU 2018-13 and ASU 2018-15 did not have a material effect on our financial position, results of operations or cash flows.

Effective January 1, 2019, as further discussed in Note 1, we adopted ASU 2016-02 using the modified retrospective transition approach as of the period of adoption.

Effective January 1, 2018, as further discussed in Note 1, we adopted ASU 2014-09 and ASU 2016-01, and we early adopted ASU 2018-02. Also effective January 1, 2018, we adopted ASU 2016-15, "Statement of Cash Flows (Topic 230) Classification of Certain Cash Receipts and Cash Payments" and ASU 2016-18, "Statement of Cash Flows (Topic 230) Restricted Cash," both of which were applied using a retrospective transition method to each period presented and did not have any effect on our statements of cash flows.

SUPPLEMENTAL FINANCIAL INFORMATION

SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)

The tables below present our quarterly results for the years ended December 31, 2020 and 2019. Quarterly amounts presented for the year ended December 31, 2019 have been adjusted to reflect the change in method of accounting for our estimated professional and general liability claims, which was implemented in March 2020. See Note 1 to the accompanying Consolidated Financial Statements for additional discussion of this change in accounting principle.

	Year Ended December 31, 2020			
	First	Second	Third	Fourth
Net operating revenues	$ 4,520	$ 3,648	$ 4,557	$ 4,915
Net income (loss)(1)	$ 159	$ 169	$ (106)	$ 546
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ 93	$ 88	$ (196)	$ 414
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic	$ 0.89	$ 0.84	$ (1.86)	$ 3.92
Diluted	$ 0.88	$ 0.83	$ (1.86)	$ 3.86

	Year Ended December 31, 2019			
	First	Second	Third	Fourth
Net operating revenues	$ 4,545	$ 4,560	$ 4,568	$ 4,806
Net income (loss)	$ 72	$ 121	$ (146)	$ 124
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (12)	$ 26	$ (226)	$ (3)
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic	$ (0.11)	$ 0.25	$ (2.18)	$ (0.03)
Diluted	$ (0.11)	$ 0.25	$ (2.18)	$ (0.03)

(1) Includes income (loss) from federal, state and local COVID-related grants of $523 million, $(70) million and $446 million during the second, third and fourth quarters, respectively, of 2020. Income (loss) recognized under these grants is reported in grant income in the accompanying Consolidated Statements of Operations, except for $12 million, $(4) million, and $9 million of grant income included in equity in earnings of unconsolidated affiliates during the second, third, and fourth quarters, respectively, of 2020. No grant income was recognized in the first quarter of 2020 or during the year ended December 31, 2019.

Quarterly operating results are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: the impact of the COVID-19 pandemic on our operations, business, financial condition and cash flows; 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; trends in patient accounts receivable collectability and associated implicit price concessions; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; gains (losses) on sales, consolidation and deconsolidation of facilities; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains (losses) from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: changes in federal, state and local healthcare and business regulations, including mandated closures and other operating restrictions; 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; disease hotspots and seasonal cycles of illness; climate and weather conditions; physician recruitment, satisfaction, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; utilization pressure by managed care organizations, as well as managed care contract negotiations or terminations; hospital performance data on quality measures and patient satisfaction, as well as standard charges for services; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and changing consumer behavior, including with respect to the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

In December 2020, subsidiaries of USPI Holding Company, Inc., in which we own 95% of the voting common stock, acquired controlling interests in 45 ambulatory surgery centers ("SCD Centers"). We have excluded all of the SCD Centers' operations from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. The SCD Centers represent 6% or our consolidated total assets and less than 1% of our consolidated net operating revenues as of and for the year ended December 31, 2020. The rules of the Securities and Exchange Commission ("SEC") require us to include acquired entities in our assessment of the effectiveness of internal control over financial reporting no later than the annual management report following the first anniversary of the acquisition. We will complete the evaluation and integration of the SCD Centers' operations within the required timeframe and report management's assessment of our internal control over financial reporting in our first annual report in which such assessment is required. Other than this transaction, there were no changes in our internal control over financial reporting during the quarter ended December 31, 2020 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Exchange Act, as of the end of the period covered by this report. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Exchange Act and the SEC rules thereunder.

Management's report on internal control over financial reporting is set forth on page 80 and is incorporated herein by reference. The independent registered public accounting firm that audited the financial statements included in this report has issued an attestation report on our internal control over financial reporting as set forth on page 81 herein.

ITEM 9B. OTHER INFORMATION

None.

PART III.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K. Information concerning our Code of Conduct, by which all of our employees and officers, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide appears under Item 1, Business – Compliance and Ethics, of Part I of this report.

ITEM 11. EXECUTIVE COMPENSATION

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

PART IV.

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The Consolidated Financial Statements and notes thereto can be found on pages 84 through 132.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 145).

All other schedules and financial statements of the Registrant are omitted because they are not applicable or not required or because the required information is included in the Consolidated Financial Statements or notes thereto.

FINANCIAL STATEMENTS REQUIRED BY RULE 3-09 OF REGULATION S-X

The consolidated financial statements of Texas Health Ventures Group, L.L.C. and subsidiaries ("THVG"), which are included due to the significance of the equity in earnings of unconsolidated affiliates we recognized from our investment in THVG for the years ended December 31, 2020, 2019 and 2018 can be found on pages F-1 through F-24.

All other schedules and financial statements of THVG are omitted because they are not applicable or not required or because the required information is included in the Consolidated Financial Statements or notes thereto.

EXHIBITS

Unless otherwise indicated, the following exhibits are filed with this report:

(3) Articles of Incorporation and Bylaws

(a) Amended and Restated Articles of Incorporation of the Registrant, as amended and restated May 8, 2008 (Incorporated by reference to Exhibit 3(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, filed August 5, 2008)

(b) Certificate of Change Pursuant to NRS 78.209, filed with the Nevada Secretary of State effective October 10, 2012 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K filed October 11, 2012)

(c) Amended and Restated Bylaws of the Registrant, as amended and restated effective January 3, 2019 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K filed January 7, 2019)

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Description of Securities Registered Pursuant to Section 12 of the Securities Exchange Act of 1934

(b) Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K filed November 9, 2001)

(c) Third Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee, relating to 6.875% Senior Notes due 2031 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed November 9, 2001)

(d) Indenture, dated as of June 16, 2015, between THC Escrow Corporation II and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6.750% Senior Notes due 2023 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K filed June 16, 2015)

(e) Supplemental Indenture, dated as of June 16, 2015, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6.750% Senior Notes due 2023 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed June 16, 2015)

(f) Twenty-Ninth Supplemental Indenture, dated as of June 14, 2017, among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 4.625% Senior Secured First Lien Notes due 2024 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed June 16, 2017)

(g) Senior Secured First Lien Notes Indenture, dated as of June 14, 2017, between THC Escrow Corporation III and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 4.625% Senior Secured First Lien Notes due 2024 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K filed June 16, 2017)

(h) Senior Secured Second Lien Notes Indenture, dated as of June 14, 2017, between THC Escrow Corporation III and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 5.125% Senior Secured Second Lien Notes due 2025 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed June 16, 2017)

(i) Unsecured Notes Indenture, dated as of June 14, 2017, between THC Escrow Corporation III and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 7.000% Senior Notes due 2025 (Incorporated by reference to Exhibit 4.5 to Registrant's Current Report on Form 8-K filed June 16, 2017)

(j) Supplemental Indenture, dated as of July 14, 2017, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A. relating to 5.125% Senior Secured Second Lien Notes Due 2025 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed July 17, 2017)

(k) Supplemental Indenture, dated as of August 1, 2017, among the Registrant and The Bank of New York Mellon Trust Company, N.A. relating to 7.000% Senior Notes Due 2025 (Incorporated by reference to Exhibit 4.5 to Registrant's Current Report on Form 8-K filed August 2, 2017)

(l) Thirtieth Supplemental Indenture, dated as of February 5, 2019, among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 6.250% Senior Secured Second Lien Notes due 2027 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed February 6, 2019)

(m) Thirty-First Supplemental Indenture, dated as of August 26, 2019, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A. relating to 4.625% Senior Secured First Lien Notes due 2024 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed August 26, 2019)

(n) Thirty-Second Supplemental Indenture, dated as of August 26, 2019, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A. relating to 4.875% Senior Secured First Lien Notes due 2026 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K filed August 26, 2019)

(o) Thirty-Third Supplemental Indenture, dated as of August 26, 2019, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A. relating to 5.125% Senior Secured First Lien Notes due 2027 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed August 26, 2019)

(p) Thirty-Fourth Supplemental Indenture, dated as of April 7, 2020, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 7.500% Senior Secured First Lien Notes Due 2025 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed April 7, 2020)

(q) Thirty-Fifth Supplemental Indenture, dated as of June 16, 2020, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 4.625% Senior Secured First Lien Notes Due 2028 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed June 16, 2020)

(r) Thirty-Sixth Supplemental Indenture, dated as of September 16, 2020, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6.125% Senior Notes Due 2028 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed September 16, 2020)

(10) Material Contracts

(a) Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed October 20, 2010)

(b) Amendment No. 1, dated as of November 29, 2011, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed December 1, 2011)

(c) Amendment No. 2, dated as of January 23, 2014, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10(c) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2013, filed February 24, 2014)

(d) Amendment No. 3, dated as of December 4, 2015, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto and Citicorp USA, Inc., as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed December 9, 2015)

(e) Amendment No. 4, dated as of September 12, 2019, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto and Citicorp USA, Inc., as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed September 13, 2019)

(f) Amendment No. 5, dated as of April 24, 2020, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto and Citicorp USA, Inc., as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed April 27, 2020)

(g) Letter of Credit Facility Agreement, dated as of March 7, 2014, among the Registrant, certain financial institutions party thereto from time to time as letter of credit participants and issuers, and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 10, 2014)

(h) Amendment No. 1, dated as of September 15, 2016, to the Letter of Credit Facility Agreement, dated as of March 7, 2014, among the Registrant, certain financial institutions party thereto from time to time as letter of credit participants and issuers, and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated filed September 16, 2016)

(i) Amendment No. 3, dated as of September 12, 2019, to the Letter of Credit Facility Agreement, dated as of March 7, 2014, by and among the Registrant, the LC participants and issuers party thereto and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed September 13, 2019)

(j) Amendment No. 4, dated as of March 19, 2020, to the Letter of Credit Facility Agreement, dated as of March 7, 2014, by and among the Registrant, the LC participants and issuers party thereto and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 24, 2020)

(k) Amendment No. 5, dated as of July 29, 2020, to the Letter of Credit Facility Agreement, dated as of March 7, 2014, by and among the Registrant, the LC participants and issuers party thereto, and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020, filed August 3, 2020)

(l) Guaranty, dated as of March 7, 2014, among Barclays Bank PLC, as administrative agent and the guarantors party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed March 10, 2014)

(m) Stock Pledge Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 5, 2009)

(n) First Amendment to Stock Pledge Agreement, dated as of May 8, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(h) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)

(o) Second Amendment to Stock Pledge Agreement, dated as of June 15, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed June 16, 2009)

(p) Third Amendment to Stock Pledge Agreement, dated as of March 7, 2014, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)

(q) Fourth Amendment to Stock Pledge Agreement, dated as of March 23, 2015, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(k) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)

(r) Fifth Amendment to Stock Pledge Agreement, dated as of December 1, 2016, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(m) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2018, filed February 25, 2019)

(s) Sixth Amendment to Stock Pledge Agreement, dated as of June 14, 2017, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(n) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2018, filed February 25, 2019)

(t) Seventh Amendment to Stock Pledge Agreement, dated as of February 5, 2019, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(o) to Registrant's Annual Report on Form 10-K for the year December 31, 2018, filed February 25, 2019)

(u) Collateral Trust Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed March 5, 2009)

(v) Exchange and Registration Rights Agreement, dated as of April 7, 2020, among the Registrant, the guarantors party thereto and Barclays Capital Inc. as representative of the other initial purchasers of the notes named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed April 7, 2020)

(w) Exchange and Registration Rights Agreement, dated as of June 16, 2020, among the Registrant, the guarantors party thereto and Barclays Capital Inc. as representative of the other initial purchasers of the notes named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed June 16, 2020)

(x) Exchange and Registration Rights Agreement, dated as of September 16, 2020, between the Registrant and Barclays Capital Inc. as representative of the other initial purchasers of the notes named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed September 16, 2020)

(y) Support Agreement, dated March 23, 2018, between the Registrant and Glenview Capital Management, LLC, Glenview Capital Partners, L.P., Glenview Capital Master Fund, Ltd., Glenview Institutional Partners, L.P., Glenview Offshore Opportunity Master Fund, Ltd. and Glenview Capital Opportunity Fund (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 26, 2018)

(z) Employment Agreement, dated March 24, 2018, by and between the Registrant and Ronald A. Rittenmeyer (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed March 26, 2018)*

(aa) Amendment No. 1 to Employment Agreement, dated February 27, 2019 (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 1, 2019)*

(bb) Amendment No. 2 to Employment Agreement, dated as of February 26, 2020 (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed February 28, 2020)*

(cc) Employment Agreement, dated November 27, 2018, by and between the Registrant and Saumya Sutaria, M.D. (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed November 30, 2018)*

(dd) Letter from the Registrant to Daniel J. Cancelmi, dated September 6, 2012 (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(ee) Letter from the Registrant to Audrey Andrews, dated January 22, 2013 (Incorporated by reference to Exhibit 10(m) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2012, filed February 26, 2013)*

(ff) Letter from the Registrant to Paola Arbour, dated May 3, 2018 (Incorporated by reference to Exhibit 10(e) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020, filed May 4, 2020)*

(gg) Retirement, General Release, and Consulting Agreement, dated as of June 19, 2019, by and between Tenet Business Services Corporation and Keith B. Pitts (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed June 21, 2019)*

(hh) Tenet Fifth Amended and Restated Executive Severance Plan, as amended and restated effective February 1, 2021*

(ii) Tenet Healthcare Corporation Tenth Amended and Restated Supplemental Executive Retirement Plan, as amended and restated effective April 1, 2018 (Incorporated by reference to Exhibit 10(cc) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2018, filed on February 25, 2019)*

(jj) Ninth Amended and Restated Tenet 2001 Deferred Compensation Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(g) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(kk) Sixth Amended and Restated Tenet 2006 Deferred Compensation Plan, as amended and restated effective January 1, 2020 (Incorporated by reference to Exhibit 10(ii) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2019, filed on February 24, 2020)*

(ll) Sixth Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan, as amended and restated effective March 10, 2016 (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016, filed August 1, 2016)*

(mm) Forms of Award used to evidence (i) initial grants of restricted stock units to directors, (ii) annual grants of restricted stock units to directors, (iii) grants of stock options to executives, and (iv) grants of restricted stock units to executives, all under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(aa) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2008, filed February 24, 2009)*

(nn) Forms of Award used to evidence (i) grants of cash-based long-term performance awards, (ii) grants of non-qualified stock option performance awards and (iii) grants of restricted stock unit awards under the Sixth Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(hh) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2017, filed February 26, 2018)*

(oo) Terms and Conditions of Non-Qualified Stock Option Performance Awards granted to Ronald A. Rittenmeyer under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017, filed November 7, 2017)*

(pp) Terms and Conditions of Restricted Stock Unit Award granted to Ronald A. Rittenmeyer under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018, filed April 30, 2018)*

(qq) Terms and Conditions of Restricted Stock Unit Award granted to Ronald A. Rittenmeyer on June 29, 2018 under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(b) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018, filed August 6, 2018)*

(rr) Terms and Conditions of Restricted Stock Unit Award granted to Ronald A. Rittenmeyer on February 27, 2019 under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(pp) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2019, filed on February 24, 2020)*

(ss) Terms and Conditions of Restricted Stock Unit Award granted to Saumya Sutaria, M.D. on January 31, 2019 under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(qq) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2019, filed on February 24, 2020)*

(tt) Terms and Conditions of Restricted Stock Unit Award granted to Saumya Sutaria, M.D. on February 27, 2019 under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(rr) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2019, filed on February 24, 2020)*

(uu) Tenet Healthcare 2019 Stock Incentive Plan (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed May 3, 2019)*

(vv) Forms of Award used to evidence (i) initial grants of restricted stock units to directors and (ii) annual grants of restricted stock units to directors, each under the Tenet Healthcare 2019 Stock Incentive Plan (Incorporated by reference to Exhibit 10(tt) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2019, filed on February 24, 2020)*

(ww) Tenet Special RSU Deferral Plan (Incorporated by reference to Exhibit 10(d) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009, filed May 5, 2009)*

(xx) Fifth Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective as of November 4, 2020*

(yy) Eighth Amended and Restated Tenet Executive Retirement Account, as amended and restated effective as of April 26, 2019 (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019, filed August 5, 2019)*

(zz) Form of Indemnification Agreement entered into with each of the Registrant's directors (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, filed November 1, 2005)

(21) Subsidiaries of the Registrant

(23) Consents

(a) Consent of Deloitte & Touche LLP

(b) Consent of PricewaterhouseCoopers LLP

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Ronald A. Rittenmeyer, Executive Chairman and Chief Executive Officer

(b) Certification of Daniel J. Cancelmi, Executive Vice President and Chief Financial Officer

(32) Section 1350 Certifications of Ronald A. Rittenmeyer, Executive Chairman and Chief Executive Officer, and Daniel J. Cancelmi, Executive Vice President and Chief Financial Officer

(101 SCH) Inline XBRL Taxonomy Extension Schema Document

(101 CAL) Inline XBRL Taxonomy Extension Calculation Linkbase Document

(101 DEF) Inline XBRL Taxonomy Extension Definition Linkbase Document

(101 LAB) Inline XBRL Taxonomy Extension Label Linkbase Document

(101 PRE) Inline XBRL Taxonomy Extension Presentation Linkbase Document

(101 INS) Inline XBRL Taxonomy Extension Instance Document – the instance document does not appear in the interactive data file because its XBRL tags are embedded within the inline XBRL document

(104) Cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2020 formatted in Inline XBRL (included in Exhibit 101)

* Management contract or compensatory plan or arrangement.

ITEM 16. FORM 10-K SUMMARY

Not applicable.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: February 19, 2021 By: /s/ R. SCOTT RAMSEY

R. Scott Ramsey
Senior Vice President, Controller
(Principal Accounting Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Date: February 19, 2021	By:	/s/ RONALD A. RITTENMEYER Ronald A. Rittenmeyer Executive Chairman and Chief Executive Officer *(Principal Executive Officer)*
Date: February 19, 2021	By:	/s/ DANIEL J. CANCELMI Daniel J. Cancelmi Executive Vice President and Chief Financial Officer *(Principal Financial Officer)*
Date: February 19, 2021	By:	/s/ R. SCOTT RAMSEY R. Scott Ramsey Senior Vice President, Controller *(Principal Accounting Officer)*
Date: February 19, 2021	By:	/s/ JAMES L. BIERMAN James L. Bierman Director
Date: February 19, 2021	By:	/s/ RICHARD FISHER Richard Fisher Director
Date: February 19, 2021	By:	/s/ CECIL D. HANEY Cecil D. Haney Director
Date: February 19, 2021	By:	/s/ MEGHAN M. FITZGERALD Meghan M. FitzGerald, DrPH Director
Date: February 19, 2021	By:	/s/ J. ROBERT KERREY J. Robert Kerrey Director
Date: February 19, 2021	By:	/s/ CHRIS LYNCH Chris Lynch Director
Date: February 19, 2021	By:	/s/ RICHARD MARK Richard Mark Director
Date: February 19, 2021	By:	/s/ TAMMY ROMO Tammy Romo Director
Date: February 19, 2021	By:	/s/ SAUMYA SUTARIA Saumya Sutaria, M.D. Director
Date: February 19, 2021	By:	/s/ NADJA WEST Nadja West, M.D. Director

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Costs and Expenses(1)(2)	Deductions(3)	Other Items(4)	Balance at End of Period
Allowance for doubtful accounts:					
Year ended December 31, 2020	$ —	$ —	$ —	$ —	$ —
Year ended December 31, 2019	$ —	$ —	$ —	$ —	$ —
Year ended December 31, 2018	$ 898	$ —	$ —	$ (898)	$ —
Valuation allowance for deferred tax assets:					
Year ended December 31, 2020	$ 281	$ (226)	$ —	$ —	$ 55
Year ended December 31, 2019	$ 148	$ 133	$ —	$ —	$ 281
Year ended December 31, 2018	$ 72	$ 76	$ —	$ —	$ 148

(1) Includes amounts recorded in discontinued operations.
(2) Before considering recoveries on accounts or notes previously written off.
(3) Accounts written off.
(4) Allowance for doubtful accounts eliminated in 2018 upon adoption of Accounting Standards Update 2014-09, “Revenue from Contracts with Customers (Topic 606)”.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

CONTENTS

Audited Financial Statements

Report of Independent Auditors

To the Board of Trustees of Baylor Scott & White Holdings

We have audited the accompanying consolidated financial statements of Texas Health Ventures Group, L.L.C. and its subsidiaries, which comprise the consolidated balance sheets as of June 30, 2020 and 2019, and the related consolidated statements of income, of changes in equity and of cash flows for each of the three years in the period ended June 30, 2020.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Texas Health Ventures Group, L.L.C. and its subsidiaries as of June 30, 2020 and 2019, and the results of their operations and their cash flows for each of the three years in the period ended June 30, 2020 in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1 to the consolidated financial statements, the Company changed the manner in which it accounts for leases as of July 1, 2019. Our opinion is not modified with respect to this matter.

/s/ PricewaterhouseCoopers LLP

Dallas, Texas
October 30, 2020

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS – AS OF JUNE 30, 2020 AND 2019
(in thousands)

	2020	2019
ASSETS		
CURRENT ASSETS:		
Cash	$ 52,739	$ 23,703
Funds due from USPI	288,180	101,282
Patient receivables	111,452	111,579
Supplies	27,720	27,017
Prepaid and other current assets	7,983	13,951
Total current assets	488,074	277,532
NON-CURRENT ASSETS:		
Property and equipment, net (Note 2)	214,493	234,423
Operating lease assets (Note 7)	245,225	—
Restricted cash	1,455	1,300
Investments in unconsolidated affiliates (Note 3)	7,531	6,837
Goodwill and intangible assets, net (Note 5)	431,797	432,000
Other	225	279
Total assets	$ 1,388,800	$ 952,371
LIABILITIES AND EQUITY		
CURRENT LIABILITIES:		
Accounts payable, including funds due to USPI of $9,860 and $10,747 at June 30, 2020 and 2019, respectively	$ 68,696	$ 78,658
Accrued expenses and other current liabilities	51,643	47,092
Contract liabilities	77,239	—
Current maturities of long-term obligations	21,372	23,249
Current portion of operating lease liabilities	32,457	—
Total current liabilities	251,407	148,999
NON-CURRENT LIABILITIES:		
Long-term obligations, net of current portion (Note 6)	144,808	161,930
Long-term operating lease liabilities, less current portion (Note 7)	230,969	—
Other liabilities	4,180	18,080
Total liabilities	631,364	329,009
COMMITMENTS AND CONTINGENCIES (Notes 6, 7, 8 and 9)		
NONCONTROLLING INTERESTS - REDEEMABLE	205,960	170,640
MEMBERS' EQUITY:		
Members' equity	515,678	419,847
Noncontrolling interests – nonredeemable	35,798	32,875
Total equity	551,476	452,722
Total liabilities and equity	$ 1,388,800	$ 952,371

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

FOR THE YEARS ENDED JUNE 30, 2020, 2019 AND 2018

(in thousands)

	2020	2019	2018
REVENUES:			
Net patient service revenue	$ 1,204,042	$ 1,216,601	$ 1,204,516
Less provision for doubtful accounts	—	—	34,636
Net patient service revenue less provision for doubtful accounts	1,204,042	1,216,601	1,169,880
Management fee income	600	600	600
Other revenue	2,029	2,668	3,053
Total revenues	1,206,671	1,219,869	1,173,533
Grant income	24,093	—	—
Equity in earnings of unconsolidated affiliates (Note 3)	5,193	4,458	5,065
OPERATING EXPENSES:			
Salaries, benefits, and other employee costs	296,560	302,202	277,721
Medical services and supplies	295,213	307,784	284,386
Management and royalty fees	45,369	46,362	41,973
Professional fees	6,828	7,700	8,679
Purchased services	63,806	64,169	56,829
Other operating expenses	135,854	146,303	137,252
Provision for doubtful accounts	—	—	25,244
Depreciation and amortization	40,286	39,962	31,829
Total operating expenses	883,916	914,482	863,913
Operating income	352,041	309,845	314,685
NONOPERATING INCOME (EXPENSES):			
Interest expense	(13,708)	(15,698)	(14,091)
Interest income (Note 8)	996	1,032	711
Other (expenses)/income, net	(83)	(32)	1,059
Net income before income taxes	339,246	295,147	302,364
Income taxes	(5,315)	(5,698)	(5,099)
Net income	333,931	289,449	297,265
Net income attributable to noncontrolling interests - redeemable	(159,632)	(141,348)	(143,580)
Net income attributable to noncontrolling interests - nonredeemable	(8,487)	(5,280)	(8,648)
Net income attributable to THVG	$ 165,812	$ 142,821	$ 145,037

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY

FOR THE YEARS ENDED JUNE 30, 2020, 2019 AND 2018

(in thousands)

		Members' Equity			
	Total Equity	USP	BUMC	Total Members' Equity	Noncontrolling Interests - Nonredeemable
Balance at June 30, 2017	$ 335,258	$ 147,737	$ 148,337	$ 296,074	$ 39,184
Net income	153,685	72,373	72,664	145,037	8,648
Distributions to members	(132,424)	(63,076)	(63,329)	(126,405)	(6,019)
Contributions from members	102,545	51,169	51,376	102,545	—
Purchase of noncontrolling interests	(5,456)	674	676	1,350	(6,806)
Sale of noncontrolling interests	(225)	633	636	1,269	(1,494)
Balance at June 30, 2018	453,383	209,510	210,360	419,870	33,513
Net income	148,101	71,268	71,553	142,821	5,280
Distributions to members	(145,615)	(69,990)	(70,270)	(140,260)	(5,355)
Purchase of noncontrolling interests	(5,526)	(2,270)	(2,280)	(4,550)	(976)
Sale of noncontrolling interests	2,379	981	985	1,966	413
Balance at June 30, 2019	452,722	209,499	210,348	419,847	32,875
Net income	174,299	82,740	83,072	165,812	8,487
Cumulative effect of change in accounting principle	68	34	34	68	—
Distributions to members	(74,992)	(35,444)	(35,586)	(71,030)	(3,962)
Purchase of noncontrolling interests	(1,750)	(365)	(366)	(731)	(1,019)
Sale of noncontrolling interests	1,129	854	858	1,712	(583)
Balance at June 30, 2020	$ 551,476	$ 257,318	$ 258,360	$ 515,678	$ 35,798

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2020, 2019 AND 2018

(in thousands)

	2020	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income	$ 333,931	$ 289,449	$ 297,265
Adjustments to reconcile net income to net cash provided by operating activities:			
Provision for doubtful accounts	—	—	59,880
Depreciation and amortization	40,286	39,962	31,829
Amortization of debt issue costs	15	12	5
Equity in earnings (losses) of unconsolidated affiliates, net of distributions received	(693)	150	156
Loss/(gain) on sale of assets	198	251	(2)
Noncash lease expense	1,077	—	—
Changes in operating assets and liabilities, net of effects from purchases of new businesses:			
Decrease/(increase) in patient receivables	126	(4,153)	(62,006)
Decrease/(increase) in supplies, prepaid, and other assets	5,266	(6,363)	(4,639)
Increase in contract liabilities	77,239	—	—
(Decrease)/increase in accounts payable, accrued expenses, and other liabilities	(243)	7,657	7,980
Net cash provided by operating activities	457,202	326,965	330,468
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchases of new businesses and equity interests, net of cash received	—	—	925
Purchases of property and equipment	(22,476)	(46,465)	(47,693)
Sale of property and equipment	182	170	206
Decrease/(increase) in deposits and notes receivables	—	35	(44)
Other investing activities	—	(284)	13
(Increase)/decrease in funds due from United Surgical Partners, Inc.	(186,898)	13,126	(21,158)
Net cash used in investing activities	(209,192)	(33,418)	(67,751)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from debt obligations	2,376	11,500	26,078
Payments on debt obligations	(21,324)	(21,829)	(49,029)
Distributions to noncontrolling interest owners	(130,340)	(145,796)	(144,265)
Purchases of noncontrolling interests	(3,867)	(12,792)	(8,215)
Sales of noncontrolling interests	5,366	7,153	9,609
Contribution from members	—	—	20,925
Distributions to members	(71,030)	(140,260)	(126,405)
Net cash used in financing activities	(218,819)	(302,024)	(271,302)
Increase/(decrease) in cash and restricted cash	29,191	(8,477)	(8,585)
Cash and restricted cash, beginning of period	25,003	33,480	42,065
Cash and restricted cash, end of period	$ 54,194	$ 25,003	$ 33,480
SUPPLEMENTAL INFORMATION:			
Cash paid for interest	$ 13,783	$ 15,776	$ 13,991
Cash paid for income taxes	—	5,222	5,076
NONCASH TRANSACTIONS:			
Assets acquired under finance lease obligations	$ —	$ 1,472	$ 32,033
(Decrease)/increase in accounts payable due to property and equipment received but not paid	(2,033)	(10,764)	12,322
Tyler acquisition	—	—	81,620
Right of use assets acquired under operating leases	9,001	—	—

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS - continued

FOR THE YEARS ENDED JUNE 30, 2020, 2019 AND 2018

(in thousands)

	2020	2019	2018
RECONCILIATION OF CASH AND RESTRICTED CASH:			
Cash at beginning of period	$ 23,703	$ 29,041	$ 32,105
Restricted cash at beginning of period	1,300	4,439	9,960
Cash and restricted cash at beginning of period	$ 25,003	$ 33,480	$ 42,065
Cash at end of period	$ 52,739	$ 23,703	$ 29,041
Restricted cash at end of period	1,455	1,300	4,439
Cash and restricted cash at end of period	$ 54,194	$ 25,003	$ 33,480

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Texas Health Ventures Group, L.L.C. and subsidiaries (THVG or the Company), a Texas limited liability company, was formed on January 21, 1997, for the primary purpose of developing, acquiring, and operating ambulatory surgery centers and related entities. THVG is a joint venture between Baylor University Medical Center (BUMC), an affiliate of Baylor Scott & White Holdings (BSW Holdings), who owns 50.1% of THVG, and USP North Texas, Inc. (USP), a Texas corporation and consolidated subsidiary of United Surgical Partners International, Inc. (USPI), who owns 49.9% of THVG. USPI is a subsidiary of Tenet Healthcare Corporation (Tenet). BSW Holdings and its controlled affiliates are referred to collectively herein as "BSWH." THVG's fiscal year ends June 30. Fiscal years of THVG's subsidiaries end December 31; however, the financial information of these subsidiaries included in these consolidated financial statements is as of June 30, 2020 and 2019, and for the years ended, June 30, 2020, 2019, and 2018.

THVG owns equity interests in and operates ambulatory surgery centers, surgical hospitals, and related businesses in Texas. At June 30, 2020, THVG operated thirty-three facilities (the Facilities) under management contracts, thirty-two of which are consolidated for financial reporting purposes and one of which is accounted for under the equity method. THVG also has one consolidated facility and one equity method investment in a facility that does not fall under a management contract. In addition, THVG holds equity method investments in two real estate partnerships that are not surgical facilities and do not have ownership in any surgical facilities, as well as a consolidated legal entity that has an investment in three of the THVG-operated surgical facilities.

THVG has been funded by capital contributions from its members and by cash distributions from the Facilities. The board of managers, which is controlled by BSWH, initiates requests for capital contributions. The Facilities' operating agreements provide that cash flows available for distribution will be distributed, at least quarterly, to THVG and other owners of the Facilities.

THVG's operating agreement provides that the board of managers determine, on at least a quarterly basis, if THVG should make a cash distribution based on a comparison of THVG's excess cash on hand versus current and anticipated needs, including, without limitation, needs for operating expenses, debt service, acquisitions, and a reasonable contingency reserve. The terms of THVG's operating agreement provide that any distributions, whether driven by operating cash flows or by other sources, such as the distribution of noncash assets or distributions in the event THVG liquidates, are to be shared according to each member's overall ownership level in THVG.

Change in Reporting Entity

From January 1, 2016 to March 1, 2018, a consolidated BUMC subsidiary, BT East Dallas JV, LLP, a separate partnership with Tenet, had a 60% controlling interest in Texas Regional Medical Center, LLC (Sunnyvale). On March 1, 2018, that partnership was restructured and Sunnyvale was combined with THVG upon contribution by the Company's members. On March 1, 2018, USP paid BUMC and Tenet approximately $4,100,000 each for its interest in Sunnyvale resulting in THVG owning a controlling 62% interest.

The transfer of ownership interests in Sunnyvale qualified as a common control transaction as defined by Accounting Standards Codification (ASC) 250-10-45-21 as BSWH held a controlling interest in the hospital before the transaction and continued to hold a controlling interest subsequent to the transaction. As a result, the commonly controlled entities, inclusive of Sunnyvale, which historically were not presented together were considered to be a different reporting entity. This change in reporting entity, which took place in fiscal year 2018 financial statements, required retrospective combination of the entities for all periods presented as if the combination had been in effect since inception of common control. For the period prior to Sunnyvale's contribution into THVG, net income attributable to non-controlling interest was calculated at the percentage used for the previous joint venture, 40%. The Company's historical consolidated balance sheets and related statements of income, changes in equity, cash flows, and related disclosures included Sunnyvale starting with BUMC's acquisition of Sunnyvale on January 1, 2016. The effect of the change to net income attributable to THVG for the year ended 2018 was approximately $2,900,000.

Basis of Accounting

THVG maintains its books and records on the accrual basis of accounting, and the consolidated financial statements are prepared in accordance with accounting principles generally accepted in the United States.

Principles of Consolidation

The consolidated financial statements include the financial statements of THVG and its wholly owned subsidiaries and other entities that THVG controls. All intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management of THVG to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash Equivalents

THVG considers all highly liquid instruments with original maturities when purchased of three months or less to be cash equivalents. There were no cash equivalents at June 30, 2020 or 2019. Under the Company's cash management system, checks issued but not presented to the bank may result in book cash overdraft balances for accounting purposes. The Company reclassifies book overdrafts to accounts payable reflecting the reinstatement of liabilities cleared in the bookkeeping process. Changes in accounts payable, including those caused by book overdrafts, are reflected as an adjustment to reconcile net income to net cash provided by operating activities in the consolidated statements of cash flows. Book overdrafts included in accounts payable were approximately $13,390,000 and $22,212,000, as of June 30, 2020 and 2019, respectively.

Restricted Cash

THVG holds cash that is restricted as collateral for use in servicing certain of its outstanding debt agreements and ongoing construction projects. Restricted cash balances were approximately $1,455,000 and $1,300,000 as of June 30, 2020 and 2019, respectively, and are classified as non-current, consistent with the nature of their intended use based on the restrictions.

Concentration of Credit Risk

Government-related programs (i.e. Medicare and Medicaid) represent the only concentrated groups of payors from which THVG has significant outstanding receivables, and management does not believe there is any significant or unusual level of credit risk associated with these receivables. Commercial and managed care receivables consist of receivables from various payors involved in diverse activities and subject to differing economic conditions, and do not represent a significant concentrated credit risk to THVG.

Supplies

Supplies, consisting primarily of pharmaceuticals and medical supplies inventories, are stated at the lower of cost or net realizable value, which approximates market value, and are expensed as used.

Property and Equipment

Property and equipment are initially recorded at cost or, when acquired as part of a business combination, at fair value at the date of acquisition. Depreciation is calculated on the straight line method over the estimated useful lives of the assets. Upon retirement or disposal of assets, the asset and accumulated depreciation accounts are derecognized, and any gain or loss is reflected in earnings or losses of the respective period. Maintenance costs and repairs are expensed as incurred; significant renewals and betterments are capitalized.

Assets held under finance leases are classified as property and equipment and amortized using the straight line method over the shorter of the useful lives or the lease terms, and the related obligations are recorded as debt. Amortization of property and

equipment held under finance leases and leasehold improvements is included in depreciation and amortization expense in the consolidated statements of income.

Prior to the adoption of ASC 842 *Leases* on July 1, 2019, THVG recorded operating lease expense on a straight-line basis unless another systematic and rational allocation was more representative of the time pattern in which the leased property is physically employed. During each year presented, THVG amortizes leasehold improvements, including amounts funded by landlord incentives or allowances for which the related deferred rent is recognized as a reduction of lease expense, over the shorter of their economic lives or the lease term.

Investments in Unconsolidated Affiliates

Investments in unconsolidated affiliates in which THVG exerts significant influence, but has less than a controlling ownership are accounted for under the equity method. THVG exerts significant influence in the operations of its unconsolidated affiliates through representation on the governing bodies of the investees and additionally, with respect to the Facilities, through contracts to manage the operations of the investees.

Equity in earnings of unconsolidated affiliates consists of THVG's share of the profits and losses generated from its noncontrolling equity investments. Because these operations are central to THVG's business strategy, equity in earnings of unconsolidated affiliates is classified as a component of operating income in the accompanying consolidated statements of income.

Goodwill

Goodwill represents the excess purchase price over the estimated fair value of net identifiable assets acquired and liabilities assumed from purchased businesses. In accordance with Financial Accounting Standards Board (FASB) ASC Topic 350, *Intangibles – Goodwill and Other*, goodwill is not amortized but is instead tested for impairment annually, and between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. The qualitative assessment includes a determination by management based on qualitative factors as to whether it is more likely than not that the fair value of the reporting unit is less than its carrying amount. If management determines that based on these factors it is more likely than not that the fair value of the reporting unit is less than its carrying value, the Company quantitatively assesses its goodwill. The Company performs the annual impairment test each year during the fourth quarter. Impairment tests are performed at the reporting unit level. Due to the similar economic characteristics of THVG's surgical facilities, THVG has only one reporting unit. The Company tests for impairment by comparing the fair value of the reporting unit to its carrying amount (including goodwill). If the fair value exceeds the carrying amount, goodwill is not impaired. If the fair value is less than the carrying amount, the Company will recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value. The loss recognized shall not exceed the total amount of goodwill recorded in the THVG reporting unit.

THVG estimates the fair value of the reporting unit using the market and income approaches. To determine the fair value of the reporting unit, the Company uses the income approach (present value of discounted cash flows) with further corroboration from the market approach (evaluation of market multiples and/or data from third-party valuation specialists). The Company applies judgment in determining the fair value of its reporting unit which is dependent on significant assumptions and estimates regarding expected future cash flows, terminal value, changes in working capital requirements, and discount rates. The factor most sensitive to change with respect to THVG's discounted cash flow analyses is the estimated future cash flows of the reporting unit which is, in turn, sensitive to THVG's estimates of future revenue growth and margins for these businesses. If actual revenue growth and/or margins are lower than estimated, the impairment test results could differ. Although the Company believes its estimates are reasonable and consistent with market participant assumptions, actual results could differ from these estimates.

A qualitative analysis of the goodwill balance was performed in June of 2020, 2019, and 2018, and no such impairments were identified.

Impairment of Long-Lived Assets

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset, or related groups of assets, may not be fully recoverable from estimated future cash flows. In the event of impairment, measurement of the amount of impairment may be based on appraisal, fair values of similar assets, or estimates of future undiscounted cash flows resulting from use and ultimate disposition of the asset. No such impairment was identified in 2020, 2019, or 2018.

Fair Value of Financial Instruments

The fair value of a financial instrument is the amount at which the instrument could be exchanged in an orderly transaction between market participants to sell the asset or transfer the liability. The Company uses fair value measurements based on quoted prices in active markets for identical assets or liabilities (Level 1), significant other observable inputs (Level 2) or unobservable inputs (Level 3), depending on the nature of the item being valued. The Company does not have financial assets or liabilities measured at fair value on a recurring basis at June 30, 2020 and 2019. The carrying amounts of cash, restricted cash, funds due from United Surgical Partners, Inc., accounts receivable, and accounts payable approximate fair value because of the short maturity of these instruments.

The fair value of the Company's long-term debt is determined by Level 2 inputs which are an estimation of the discounted future cash flows of the debt at rates currently quoted or offered to a comparable company for similar debt instruments of comparable maturities by its lenders. At June 30, 2020, the aggregate carrying amount and estimated fair value of notes payable to financial institutions are approximately $41,628,000 and $38,944,000 respectively. At June 30, 2019, the aggregate carrying amount and estimated fair value of long-term debt were approximately $52,438,000 and $46,424,000, respectively.

Revenue Recognition

Effective July 1, 2018, THVG adopted the FASB Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)* and related clarifying standards (ASC 606) using a modified retrospective method of application to all contracts which were not completed as of July 1, 2018. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The adoption of ASU 2014-09 resulted in changes to the presentation and disclosure of amounts the Company previously classified as a provision for doubtful accounts in line with the guidance set forth by ASC 605, *Revenue Recognition*. A significant portion of amounts previously recorded within the provision for doubtful accounts relate to self-pay patients, co-pays, co-insurance amounts, and deductibles owed to it by patients with insurance. Under ASU 2014-09, the estimated uncollectible amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net patient service revenues. For the years ended June 30, 2020 and 2019, THVG recorded $70,557,000 and $66,277,000, respectively, of implicit price concessions as a direct reduction of net patient service revenues that would have been recorded within the Company's provision for doubtful accounts prior to the adoption of ASU 2014-09. THVG's accounting policies related to revenues were revised to reflect the adoption of ASC 2014-09 effective July 1, 2018. There was no impact to net accounts receivable on the balance sheet for the year ended June 30, 2019 related to the adoptions of ASC 2014-09.

All subsidiaries of THVG, except for Sunnyvale, assessed the ability of each patient to pay prior to providing service; therefore, the estimate of uncollectible amounts related to these entities was presented within the provision for doubtful accounts in the operating expenses section of the consolidated statements of income prior to the adoption of ASU 2014-09. Sunnyvale does not assess the ability to pay prior to providing service, and as such, the related estimate of uncollectible amounts for this entity was presented within the provision for doubtful accounts as a component of total revenues prior to the adoption of ASU 2014-09. Under ASU 2014-09, all estimated uncollectible amounts whether ability to pay is assessed prior to providing service or not, are accounted for as a direct reduction to net patient service revenues.

THVG has agreements with third-party payors that provide for payments to THVG at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amount from patients and third-party payors (including managed care payors and government programs) for services rendered. Amounts recorded as net patient service revenue include estimated contractual adjustments under reimbursement agreements with third-party payors, discounts provided to uninsured patients in accordance with the Company's policy, and implicit price concessions. The Company determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and

historical experience. The Company bases its estimate of implicit price concessions on historical collection experience using a portfolio approach, as a practical expedient, rather than arriving at an individualized estimate for each patient service encounter. The financial statement effects of using this practical expedient are not material as compared to estimating implicit price concessions on an individual basis. Contractual adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Net patient service revenue is reported at the amount that reflects consideration to which THVG expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including managed care payors and government programs) and others. Generally, THVG collects co-payments from patients at the time of service. After the service is complete, THVG prepares a final bill for the patient and third-party payor. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Company. Revenue for performance obligations satisfied over time generally relates to inpatient acute care services and is recognized based on actual charges incurred in relation to total expected (or actual) charges. Revenue for performance obligations satisfied at a point in time generally relate to patients receiving outpatient services, when: (1) services are provided; and (2) THVG does not believe the patient requires additional services.

Any unsatisfied or partially unsatisfied performance obligations primarily relate to in-house patients receiving inpatient acute care services as of the end of the reporting period. Based on the average length of stays, the performance obligations for these contracts have a duration of less than one year and are completed when patients are discharged, which generally occurs within days or weeks of the end of the reporting period. Because all of its performance obligations relate to contracts with a duration of less than one year, THVG has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period.

For the years ended June 30, 2020 and 2019, the composition of net patient service revenue by primary payor is as follows:

	2020	2019
Managed care	$ 892,754	$ 896,828
Medicare	261,417	230,274
Medicaid	7,136	14,342
Indemnity, self-pay, and other	42,735	75,157
	$ 1,204,042	$ 1,216,601

For facilities licensed as hospitals, federal regulations require the submission of annual cost reports covering medical costs and expenses associated with services provided to program beneficiaries. Medicare and Medicaid cost report settlements are estimated in the period services are provided to beneficiaries. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is a reasonable possibility that recorded estimates with respect to the ten THVG facilities licensed as hospitals may change as interpretations are clarified. These initial estimates are revised as needed until final cost reports are settled.

The Company provides charity care to patients who are financially unable to pay for the health care services they receive. The determination of charity care is generally made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of patients to pay. The discount amount is generally based on household income compared to the Federal Poverty Limit for the year. The Company’s charity policy is intended to satisfy the requirements in Section 501(r) of the Internal Revenue Code of 1986, as amended, regarding financial assistance and emergency medical care policies, limitations on charges to persons eligible for financial assistance, and reasonable billing and collection efforts. The Company’s policy is not to pursue collection of amounts determined to qualify as charity care; therefore, the Company does not report these amounts in net patient care revenues.

The Company’s estimated costs (based on the selected operating expenses, which include allocated personnel costs, supplies, other operating expenses, and management fee) of caring for charity care patients for the years ended June 30, 2020, 2019, and 2018, was approximately $15,900,000, $15,000,000, and $7,800,000, respectively.

Income Taxes

No amounts for federal income taxes have been reflected in the accompanying consolidated financial statements because the federal tax effects of THVG's activities accrue to the individual members.

The Texas franchise tax applies to all THVG entities and is reflected in the accompanying consolidated statements of income. The tax is calculated on a margin base and is therefore reflected in THVG's consolidated statements of income for the years ended June 30, 2020, 2019, and 2018 as income tax.

THVG follows the provisions of ASC 740 *Income Taxes* which prescribes a single model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing the minimum recognition threshold a tax position is required to meet before being recognized in the financial statements.

As of June 30, 2020 and 2019, THVG had no gross unrecognized tax benefits. THVG files a partnership income tax return in the U.S. federal jurisdiction and a franchise tax return in the state of Texas. THVG is no longer subject to U.S. federal income tax examination for years prior to 2016 and no longer subject to state and local income tax examination for fiscal years prior to 2015. THVG has identified Texas as a "major" state taxing jurisdiction. THVG does not expect or anticipate a significant change over the next twelve months in the unrecognized tax benefits.

THVG's policy for recording interest and penalties associated with income tax matters is to record such items to income tax expense in the consolidated statements of income. There are no interest and penalties for the years ended June 30, 2020, 2019, and 2018.

Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines and penalties, and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated.

Other Comprehensive Income

THVG does not have any items that qualify for treatment as other comprehensive income, therefore THVG's net income equals other comprehensive income.

Impact of the COVID-19 Pandemic

In March 2020, the global COVID-19 pandemic began to significantly affect THVG's patients, communities, employees, and business operations. As the COVID-19 crisis is still evolving, much of its long-term impact remains unknown and difficult to predict. The spread of COVID-19 and the ensuing response of federal, state, and local authorities beginning in March 2020 resulted in a material reduction in the Company's patient volumes and operating revenues. From mid-March through early May 2020, THVG facilities cancelled a substantial number of elective procedures and closed, or reduced, operating hours. Restrictive measures, such as travel bans, social distancing, quarantines, and shelter-in-place orders reduced the volume of procedures performed at the facilities more generally. During the pandemic, the Company has taken, and continues to take, various actions to increase its liquidity and mitigate the impact of reductions in its patient volumes and operating revenues from the COVID-19 pandemic. These actions have included several cash flow preservation and expense minimization initiatives such as deferral of lease and debt payments when approved by landlords and lenders, and rent abatements when approved by landlords. Furthermore, the Company furloughed some employees, delayed cash distributions to partners, and deferred certain operating expenses that are not expected to impact THVG's response to COVID-19. The Company believes these actions, together with government relief packages, to the extent available, will help it to continue operating and be able to meet current obligations and those coming due within the next 12 months.

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which was signed into law on March 27, 2020, and other legislative actions have mitigated some of the economic disruption caused by the COVID-19 pandemic. For the year ended June 30, 2020, THVG received cash payments of approximately $25,510,000 from the Provider Relief Fund (PRF) as part of the CARES Act. The Company recognized approximately $24,093,000 and $276,000 as grant income, and in equity in earnings of unconsolidated affiliates, respectively, in the accompanying consolidated statements of income pursuant to federal legislation and from state grant sources such as the Texas Hospital Association Foundation. Also for the year ended June 30, 2020, the Company received advance payments of approximately $77,239,000 from the Medicare accelerated payment program and recorded these funds on the consolidated balance sheets within contract liabilities. In addition, beginning March 27, 2020,

all employers had the option to elect to defer payment of the 6.2% employer Social Security tax through December 31, 2020. Deferred tax amounts are required to be paid in equal amounts over two years, with payments due in December 2021 and December 2022. As of June 30, 2020, the Company has deferred approximately $2,570,000 of taxes pursuant to this CARES Act provision, and these are classified on the consolidated balance sheets within other liabilities.

The full impact of the COVID-19 pandemic on THVG, including the results of operations and the financial condition of the Company, is highly uncertain, will depend on future developments, and could be material to THVG's consolidated financial statements in future reporting periods.

Recently Adopted Accounting Pronouncements

In February 2016, FASB issued ASU 2016-02, "*Leases* (Topic 842)" (ASU 2016-02), and has subsequently issued supplemental and/or clarifying ASUs (collectively "ASC 842"), which affects any entity that enters into a lease (as that term is defined in ASC 842), with some specified scope exceptions. The main difference between the guidance in ASC 842 and ASC 840 is the recognition of right of use assets and lease liabilities by lessees for those leases classified as operating leases under current generally accepted accounting principles (GAAP). Recognition of these assets and liabilities had a material impact to THVG's consolidated balance sheet upon adoption. In transition, the lease standard is required to be applied to leases in existence as of the date of initial application using a modified retrospective transition approach, which includes a number of optional practical expedients. This guidance was effective for the Company on July 1, 2019, and the Company used the modified retrospective method as of the period of adoption, meaning that its consolidated financial statements for periods prior to July 1, 2019 were not modified for the application of the new lease accounting standard. The Company elected the three packaged transitional practical expedients under ASC 842-10-65-1(f), to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial indirect costs for existing leases. The Company also elected the practical expedient that allows lessees to choose to not separate lease and non-lease components by class of underlying asset. At July 1, 2019, the Company increased its consolidated assets by approximately $268,700,000 and the liabilities by approximately $285,800,000 related to on-balance sheet recognition of operating lease assets and liabilities. The right of use asset recognition includes the reclassification of $17,200,000 of deferred lease liabilities. The Company also recognized a cumulative effect adjustment of approximately $68,000 that increased retained earnings at July 1, 2019.

New Accounting Pronouncements

In August 2018, the FASB issued ASU 2018-15, "*Intangibles - Goodwill and Other - Internal-Use Software (Topic 220)*." The ASU is intended to improve the recognition and measurement of financial instruments. The new guidance aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract, with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. This ASU is effective for public entities for fiscal years beginning after December 15, 2019, with early adoption permitted. The Company will adopt this standard as of fiscal year 2021. The Company does not expect adoption of this guidance to have a material effect on the Company's balance sheet, statement of operations, or statement of cash flows.

In August 2018, the FASB issued ASU 2018-13, *"Fair Value Measurement (Topic 820) Disclosure Framework—Changes to the Disclosure Requirements for Fair Value Measurement,"* which applies to all entities that are required to make disclosures about recurring or nonrecurring fair value measurements. The amendments in ASU 2018-13, which remove, modify, or add certain disclosure requirements will be adopted by the Company beginning fiscal year 2021. The adoption of this guidance will not impact the Company's balance sheet, statement of operations, or statement of cash flows.

In June 2016, FASB issued ASU 2016-13, "*Financial Instruments-Credit Losses (Topic 326).*" The current standard delays the recognition of a credit loss on a financial asset until the loss is probable of occurring. This ASU and related amendments remove the requirement that a credit loss be probable of occurring for it to be recognized. Instead, the new standard requires entities to use historical experience, current conditions, and reasonable and supportable forecasts to estimate their future expected credit losses. The provisions of this guidance are to be adopted by THVG in fiscal year 2021. The Company is currently evaluating the impact of this ASU.

2. PROPERTY AND EQUIPMENT

At June 30, 2020 and 2019, property and equipment and related accumulated depreciation and amortization consisted of the following (in thousands):

	Estimated Useful Lives	2020	2019
Land	—	$ 1,741	$ 1,697
Buildings and leasehold improvements	10-40 years	272,883	272,270
Equipment	3-15 years	228,481	226,032
Furniture and fixtures	10 years	10,512	10,455
Construction in progress		677	1,250
		514,294	511,704
Less accumulated depreciation		(299,801)	(277,281)
Property and equipment, net		$ 214,493	$ 234,423

At June 30, 2020 and 2019, assets recorded under finance lease arrangements included in property and equipment consisted of the following (in thousands):

	2020	2019
Buildings	$ 142,603	$ 142,519
Equipment and furniture	3,692	3,367
	146,295	145,886
Less accumulated depreciation	(74,352)	(65,786)
Net property and equipment under finance leases	$ 71,943	$ 80,100

3. INVESTMENTS IN SUBSIDIARIES AND UNCONSOLIDATED AFFILIATES

THVG's investments in consolidated subsidiaries and unconsolidated affiliates consisted of the following:

			Percentage Owned		
Legal Name	Facility	City	June 30, 2020	June 30, 2019	June 30, 2018
Consolidated subsidiaries [1]:					
DeSoto Surgicare, Ltd.	North Texas Surgery Center	Desoto	55.2 %	55.2 %	52.1 %
Metroplex Surgicare Partners, Ltd.	Baylor Surgicare at Bedford	Bedford	65.8	65.8	65.8
Baylor Surgicare at North Dallas, LLC	Baylor Surgicare at North Dallas	Dallas	54.5	56.9	56.9
Fort Worth Surgicare Partners, Ltd.	Baylor Hospital of Fort Worth	Fort Worth	51.7	51.7	50.7
Denton Surgicare Partners, Ltd.	Baylor Surgicare at Denton	Denton	50.3	50.5	50.5
Garland Surgicare Partners, Ltd.	Baylor Surgicare at Garland	Garland	50.1	50.1	50.1
University Surgical Partners of Dallas, L.L.P.[2]	N/A	Dallas	68.6	68.6	68.1
Dallas Surgical Partners, L.L.C.	Baylor Surgicare	Dallas	50.4	50.4	54.6
MSH Partners, L.L.C.	Baylor Medical Center at Uptown	Dallas	34.8	34.9	34.9
North Central Surgical Center, L.L.P.	North Central Surgery Center	Dallas	35.1	35.2	34.4
Grapevine Surgicare Partners, Ltd.	Baylor Surgicare at Grapevine	Grapevine	53.9	53.9	53.5
Frisco Medical Center, L.L.P.	Baylor Scott & White Medical Center - Frisco	Frisco	52.4	51.9	50.5
Physicians Center of Fort Worth, L.L.P.	Baylor Surgicare at Fort Worth I & II	Fort Worth	53.3	53.3	54.0
Bellaire Outpatient Surgery Center, L.L.P.	Baylor Surgicare at Oakton	Fort Worth	27.1	26.4	25.8
Park Cities Surgery Center, L.L.C.	Park Cities Surgery Center	Dallas	50.1	50.1	50.1

Legal Name	Facility	City	Percentage Owned		
			June 30, 2020	June 30, 2019	June 30, 2018
Trophy Club Medical Center, L.P.	Baylor Medical Center at Trophy Club	Fort Worth	51.1	50.8	50.7
North Garland Surgery Center, L.L.P.	Baylor Surgicare at North Garland	Garland	51.8	54.5	54.3
Rockwall Ambulatory Surgery Center, L.L.P.	Rockwall Surgery Center	Rockwall	54.7	54.7	54.7
Baylor Surgicare at Plano, L.L.C.	Baylor Surgicare at Plano	Plano	50.3	50.1	50.1
Arlington Orthopedic and Spine Hospitals, LLC	Baylor Orthopedic and Spine Hospital at Arlington	Arlington	50.1	50.1	50.1
Baylor Surgicare at Granbury, LLC	Baylor Surgicare at Granbury	Granbury	51.2	51.2	51.2
Metrocrest Surgery Center, L.L.C.	Baylor Surgicare at Carrollton	Carrollton	51.0	51.0	53.5
Baylor Surgicare at Mansfield, L.L.C.	Baylor Surgicare at Mansfield	Mansfield	50.4	50.4	50.1
Tuscan Surgery Center, L.L.C.	Tuscan Surgery Center at Las Colinas	Las Colinas	51.0	53.7	55.5
Lone Star Endoscopy Center, L.L.C.	Lone Star Endoscopy	Keller	51.0	51.0	51.0
Baylor Surgicare at Plano Parkway, L.L.C.	Baylor Surgicare at Plano Parkway	Plano	51.0	51.0	51.0
Texas Endoscopy Centers, LLC	Texas Endoscopy	Plano/Allen	51.0	51.0	51.0
Heritage Park Surgical Hospital, LLC	Baylor Scott & White Surgical Hospital - Sherman	Sherman	52.7	52.6	52.5
Centennial ASC, LLC	Frisco Centennial Surgery Center	Frisco	50.2	50.2	50.2
Baylor Surgicare at Baylor Plano, LLC	Baylor Plano Campus	Plano	26.3	26.5	25.3
Texas Spine and Joint Hospital, LLC	Texas Spine and Joint	Tyler	54.5	54.6	54.5
Baylor Surgicare at Blue Star, LLC	Frisco Star	Frisco	26.7	26.5	25.8
Texas Regional Medical Center, LLC	Sunnyvale Hospital	Sunnyvale	64.3	62.8	62.1
SPC at the Star, LLC	SPC at the Star	Frisco	52.4	51.9	50.5

Legal Name	Facility	City	Percentage Owned		
			June 30, 2020	June 30, 2019	June 30, 2018
Unconsolidated affiliates:					
Denton Surgicare Real Estate, Ltd. [3]	N/A	N/A	49.0 %	49.0 %	49.0 %
Irving-Coppell Surgical Hospital, L.L.P.	Irving-Coppell Surgical Hospital	Irving	19.9	19.4	19.3
MCSH Real Estate Investors, Ltd. [3]	N/A	N/A	2.0	2.0	2.0
Fusionetics, LLC	Fusionetics	Frisco	15.8	15.0	15.8

1. List excludes holding companies, which are wholly-owned by the Company and hold the Company's investments in the Facilities.
2. Partnership that has investment in North Central Surgical Center, Baylor Surgicare, and Baylor Medical Center at Uptown.
3. These entities are not surgical facilities and do not have ownership in any surgical facilities.

On August 2, 2017, Texas Health Venture Texas Spine, LLC, a wholly-owned subsidiary of THVG, completed its acquisition of Texas Spine and Joint Hospital, LLC (Tyler), resulting in a 50.25% controlling interest. The consideration of $40,900,000 and $40,700,000 was paid to the sellers by BSWH and USP, respectively. From the date of contribution to June 30, 2018, THVG recognized approximately $98,600,000 of total revenues and approximately $5,800,000 of net income from Tyler. For the twelve months ended June 30, 2019, THVG recognized approximately $117,600,000 of total revenues and approximately $12,000,000 of net income from Tyler. For the twelve months ended June 30, 2020, THVG recognized approximately $131,300,000 of total revenues and approximately $23,800,000 of net income from Tyler.

The following table summarizes the recorded values of the assets and liabilities as of the contribution date (in thousands):

	Tyler
Cash and cash equivalents	$ 925
Current assets	15,703
Long-term assets	18,276
Goodwill	111,831
Total assets acquired	146,735
Current liabilities	10,127
Long-term liabilities	4,378
Total liabilities assumed	14,505
Noncontrolling interest	50,610
Net assets acquired	$ 81,620

The assets and liabilities were accounted for at their respective fair values at the date of acquisition. Noncontrolling interests (NCI) are valued upon acquisition with a discount to reflect lack of control and marketability by the NCI holders. These fair value measurements are determined by Level 2 inputs. The resulting goodwill is attributed to expected synergies from combining operations. The results of this contributed facility are included in THVG's consolidated financial statements from the date of contribution.

The following table presents the unaudited pro forma results as if THVG had acquired Tyler on July 1, 2017 (in thousands). The pro forma results are not necessarily indicative of the results of operations that would have occurred if the acquisitions were completed on the date indicated, nor is indicative of the future operating results of THVG.

	Year Ended June 30,		
	2020	2019	2018
Total revenues	$ 1,206,671	$ 1,219,869	$ 1,178,160
Net income attributable to THVG	$ 165,812	$ 142,821	$ 143,420

4. NONCONTROLLING INTERESTS

The Company controls and therefore consolidates the results of 33 of its 35 operating facilities at June 30, 2020. Similar to its investments in unconsolidated affiliates, the Company regularly engages in the purchase and sale of equity interests with respect to its consolidated subsidiaries that do not result in a change of control. These transactions are accounted for as equity transactions, as they are undertaken among the Company, its consolidated subsidiaries, and noncontrolling interests, and their cash flow effects are classified within financing activities.

During the fiscal year ended June 30, 2020, the Company purchased and sold equity interests in various consolidated subsidiaries in the amounts of approximately $3,867,000 and $5,366,000, respectively. During the fiscal year ended June 30, 2019, the Company purchased and sold equity interests in various consolidated subsidiaries in the amounts of approximately $12,792,000 and $7,153,000, respectively. During the fiscal year ended June 30, 2018, the Company purchased and sold equity interests in various consolidated subsidiaries in the amounts of approximately $8,215,000 and $9,609,000 respectively. The basis difference between the Company's carrying amount and the proceeds received or paid in each transaction is recorded as an adjustment to the Company's equity.

The impact of these transactions is summarized as follows (in thousands):

	Year Ended June 30,		
	2020	2019	2018
Net income attributable to the company	$ 165,812	$ 142,821	$ 145,037
Net transfers to the noncontrolling interests:			
(Decrease)/increase in the Company's equity for (losses)/gains related to purchase of subsidiaries' equity interests	(731)	(4,550)	1,350
Increase in the Company's equity for gains related to sales of subsidiaries' equity interests	1,712	1,966	1,269
Net transfers to noncontrolling interests	981	(2,584)	2,619
Net increase in the company's equity due to equity interest transactions with noncontrolling interests	$ 166,793	$ 140,237	$ 147,656

Upon the occurrence of various fundamental regulatory changes, the Company could be obligated, under the terms of its investees' partnership and operating agreements, to purchase some or all of the noncontrolling interests related to the Company's consolidated subsidiaries. As a result, these noncontrolling interests are not included as part of the Company's equity and are carried as noncontrolling interests-redeemable on the Company's consolidated balance sheets. The activity in noncontrolling interests-redeemable for the years ended June 30, 2020, 2019, and 2018 is summarized below (in thousands):

Balance, June 30, 2017	$ 109,147
Net income attributable to noncontrolling interests	143,580
Distributions to noncontrolling interests	(138,245)
Purchases of noncontrolling interests	(2,512)
Sales of noncontrolling interests	9,836
Noncontrolling interests attributable to business acquisition	50,610
Balance, June 30, 2018	172,416
Net income attributable to noncontrolling interests	141,348
Distributions to noncontrolling interests	(140,441)
Purchases of noncontrolling interests	(7,457)
Sales of noncontrolling interests	4,774
Balance, June 30, 2019	170,640
Net income attributable to noncontrolling interests	159,632
Distributions to noncontrolling interests	(126,378)
Purchases of noncontrolling interests	(2,171)
Sales of noncontrolling interests	4,237
Balance, June 30, 2020	$ 205,960

5. GOODWILL AND INTANGIBLES

The following is a summary of changes in the carrying amount of goodwill for the years ended June 30, 2020 and 2019 (in thousands):

Balance, June 30, 2018	$ 431,608
Additions:	—
Balance, June 30, 2019	431,608
Additions:	—
Balance, June 30, 2020	$ 431,608

Goodwill additions resulting from business combinations are recorded and assigned to the parent and noncontrolling interests. There were no transactions in 2020 or 2019 resulting in a change in goodwill.

The Company has non-compete contracts recorded as intangible assets, which are subject to amortization. The gross carrying amount of the non-compete contract intangibles as of June 30, 2020 and 2019 was approximately $676,000. The accumulated amortization as of June 30, 2020 and 2019 was $487,000 and $351,000, respectively. The aggregate amortization expense for the non-compete contract intangibles for the years ended June 30, 2020, 2019, and 2018 was approximately $137,000, $118,000, and $80,000, respectively.

The estimated aggregate amortization expense for the fiscal year ending June 30, 2021 is $137,000 and $52,000 for fiscal year ending June 30, 2022. The recorded intangible assets are fully amortized by fiscal year 2022.

6. LONG-TERM OBLIGATIONS

At June 30, 2020 and 2019, long-term obligations consisted of the following (in thousands):

	2020	2019
Finance lease obligations (Note 7)	$ 124,552	$ 132,741
Notes payable to financial institutions	41,628	52,438
Total long-term obligations	166,180	185,179
Less current portion	(21,372)	(23,249)
Long-term obligations, less current portion	$ 144,808	$ 161,930

The aggregate maturities of notes payable for each of the five years subsequent to June 30, 2020 and thereafter are as follows (in thousands):

2021	$ 11,636
2022	11,104
2023	8,955
2024	5,806
2025	2,904
Thereafter	1,223
Total long-term obligations	$ 41,628

The Facilities have notes payable to financial institutions which mature at various dates through 2025 and accrue interest at fixed and variable rates ranging from 2% to 8%. The weighted average interest rate of the notes as of June 30, 2020 was 4.43%. The payment terms of the notes payable generally require monthly payments, with some agreements having quarterly payments. Each note is collateralized by certain assets of the respective facility. Many of the notes contain various restrictive covenants, including financial covenants that limit THVG's ability and the ability of the Facilities to borrow money or guarantee other indebtedness, grant liens, make investments, sell assets, and pay dividends. The Company believes it is in accordance with all of the covenants as of June 30, 2020.

Finance lease obligations are collateralized by underlying real estate or equipment and have interest rates ranging from 1% to 13%.

7. LEASES

THVG determines if an arrangement is a lease at inception of the contract. The right-of-use assets represent the Company's right to use the underlying assets for the lease term and the lease liabilities represent the Company's obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. The Company uses its estimated incremental borrowing rate, which is derived from information available at the lease commencement date, in determining the present value of lease payments. The Company estimates an incremental borrowing rate for each center by utilizing historical and projected financial data, estimating

a hypothetical credit rating using publicly available market data, and adjusting the market data to reflect the effects of collateralization.

THVG's operating leases are primarily for real estate, including outpatient facilities and corporate and other administrative offices, as well as medical and office equipment. The Company's finance leases are primarily for medical equipment, along with select real estate assets. The Company's real estate agreements typically have initial terms of five to 10 years, and its equipment lease agreements typically have initial terms of three years. The Company does not record leases with an initial term of 12 months or less ("short-term leases") in its consolidated balance sheets.

The Company's real estate leases may include one or more options to renew, with renewals that can extend the lease term from five to 10 years. The exercise of lease renewal options is at the Company's sole discretion. In general, THVG does not consider renewal options to be reasonably likely to be exercised, therefore, renewal options are generally not recognized as part of its right-of-use assets and lease liabilities. Certain leases also include an option to purchase the leased property. The useful life of assets and leasehold improvements are limited by the lease term, unless there is a transfer of title or purchase option reasonably certain of exercise. Many medical equipment leases have terms with a bargain purchase option that is reasonably certain of exercise, so medical equipment assets can have useful lives that can range on average from three to five years.

Certain lease agreements for real estate include payments based on actual common area maintenance expenses and others include rental payments adjusted periodically for inflation. These variable lease payments are recognized in other operating expenses, but are not included in the right-of-use asset or liability balances. The Company's lease agreements do not contain any material residual value guarantees, restrictions or covenants.

The following table presents the components of the Company's right-of-use assets and liabilities related to leases and their classification in the consolidated balance sheet at June 30, 2020 (in thousands):

Component of Lease Balances	Classification in Consolidated Balance Sheet	June 30, 2020
Assets:		
Operating lease assets	Operating lease assets	$ 245,225
Finance lease assets	Property and equipment, net	71,943
Total leased assets		$ 317,168
Liabilities:		
Operating lease liabilities:		
Current	Current portion of operating lease liabilities	$ 32,457
Long-term	Long-term operating lease liabilities, less current portion	230,969
Total operating lease liabilities		263,426
Finance lease liabilities:		
Current	Current portion of long-term debt	9,685
Long-term	Long-term debt, net of current portion	114,867
Total finance lease liabilities		124,552
Total lease liabilities		$ 387,978

The following table presents the components of the Company's lease expense and their classification in the consolidated statement of income for the year ended June 30, 2020 (in thousands):

Component of Lease Expense	Classification in Consolidated Statement of Income	Year Ended June 30, 2020
Operating lease expense	Other operating expenses	$ 41,245
Finance lease expense:		
Amortization of leased assets	Depreciation and amortization	8,382
Interest on lease liabilities	Interest expense	11,582
Total finance lease expense		19,964
Variable lease expense	Other operating expenses	8,087
Short-term lease expense	Other operating expenses	1,502
Sublease income	Other operating expenses	(305)
Total lease expense		$ 70,493

The weighted-average lease terms and discount rates for operating and finance leases are presented in the following table:

Weighted Average Lease Terms	June 30, 2020
Weighted-average remaining lease term (years)	
Operating leases	8.81
Finance leases	9.29
Weighted-average discount rate	
Operating leases	4.04 %
Finance leases	9.41 %

Cash flow and other information related to leases is included in the following table (in thousands):

	Year Ended June 30, 2020
Cash paid for amounts included in the measurement of lease liabilities	
Operating cash outflows from operating leases	$ 42,207
Operating cash outflows from finance leases	11,637
Financing cash outflows from finance leases	8,132
Right-of-use assets obtained in exchange for lease obligations	
Operating leases	$ 9,001
Finance leases	—

Future maturities of lease liabilities as of June 30, 2020 are as follows (in thousands):

	Finance Leases	Operating Leases
Year ending June 30:		
2021	$ 20,960	$ 41,693
2022	20,041	39,928
2023	19,437	36,257
2024	20,073	33,486
2025	20,404	29,194
Thereafter	86,590	134,757
Total minimum lease payments	187,505	315,315
Amount representing interest	(62,953)	(51,889)
Present value of minimum lease payments	$ 124,552	$ 263,426

Future maturities of lease liabilities as of June 30, 2019, prior to the Company's adoption of ASU 2016-02, with remaining terms in excess of one year, are as follows (in thousands):

	Capital Leases	Operating Leases
Year ending June 30:		
2020	$ 20,565	$ 39,576
2021	20,858	37,875
2022	19,994	36,542
2023	19,432	34,991
2024	20,073	33,399
Thereafter	106,914	163,108
Total minimum lease payments	$ 207,836	$ 345,491
Amount representing imputed interest	(75,095)	
Present value of minimum lease payments	$ 132,741	

Total rent expense under operating leases was approximately $50,529,000, $51,417,000, and $48,190,000 for the years ended June 30, 2020, 2019, and 2018, respectively, and is included in other operating expenses in the accompanying consolidated statements of income.

8. RELATED-PARTY TRANSACTIONS

THVG operates the Facilities under management and royalty contracts, and THVG in turn is managed by BSWH and USP, resulting in THVG incurring management and royalty fee expense payable to BSWH and USP in amounts equal to the management and royalty fee income THVG receives from the Facilities. THVG's management and royalty fee income from the facilities it consolidates for financial reporting purposes eliminates in consolidation with the facilities' expense and therefore is not included in THVG's consolidated revenues. THVG's management and royalty fee income from facilities which are not consolidated was $600,000 for each of the years ended June 30, 2020, 2019, and 2018, and is included in other revenue in the accompanying consolidated statements of income.

The management and royalty fee expense to BSWH and USP was approximately $45,369,000, $46,362,000, and $41,973,000 for the years ended June 30, 2020, 2019, and 2018, respectively, and is reflected in operating expenses in THVG's consolidated statements of income. For each year presented, of the total, 64.3% and 1.7% represent management fees payable to USP and BSWH, respectively, and 34% represents royalty fees payable to BSWH, with the exception of Sunnyvale, whose management fees are payable 55.6% and 44.4% to USP and BSWH, respectively.

Under the management and royalty agreements, the Facilities pay THVG an amount ranging from 5.0% to 7.0% of their net patient service revenue annually, subject, in some cases, to an annual cap.

In addition, a subsidiary of USPI pays certain expenses, primarily related to insurance premiums, data warehousing, and accounts payables processing, on behalf of THVG which are recorded within the operating expenses section of the accompanying consolidated statements of income. These expenses, net of management fees attributable to USPI, amounted to $43,784,000, $45,940,000, and $57,553,000 for the years ended June 30, 2020, 2019, and 2018, respectively.

USPI holds funds through an arrangement with THVG by which cash on hand at certain of THVG's bank accounts is swept to USPI on a daily basis. USPI pays THVG interest income at the Federal Reserve Prime rate less 2.5% of the average daily balance. USPI pays the Facilities interest income at 0.25% of the Facilities' average daily balance. Amounts held by USPI on behalf of THVG and the Facilities, shown in Funds due from United Surgical Partners, Inc. on the accompanying consolidated balance sheets, totaled approximately $288,180,000 and $101,282,000 at June 30, 2020 and 2019, respectively. Accrued expenses that USPI paid on behalf of THVG, shown in accounts payable on the accompanying consolidated balance sheets, totaled approximately $9,860,000 and $10,747,000 at June 30, 2020 and 2019, respectively. The interest income associated with this arrangement amounted to approximately $996,000, $1,032,000, and $711,000 for the years ended June 30, 2020, 2019, and 2018, respectively.

9. COMMITMENTS AND CONTINGENCIES

Financial Guarantees

THVG guarantees portions of the indebtedness of its investees to third-parties, which could potentially require THVG to make maximum aggregate payments totaling approximately $3,347,000. Of the total, approximately $1,122,000 relates to the finance lease obligations of two consolidated subsidiaries, and approximately $2,225,000 relates to the operating lease obligations of one consolidated subsidiary. Both obligations are included in THVG's consolidated balance sheets and related disclosures.

These arrangements (a) consist of guarantees of real estate and equipment financing and lease obligations, (b) are collateralized by all, or a portion of, the investees' assets, (c) require payments by THVG in the event of a default by the investee primarily obligated under the financing, (d) expire as the underlying debt matures at various dates through 2025, or earlier if certain performance targets are met, and (e) provide no recourse for THVG to recover any amounts from third-parties. The aggregate fair value of the guarantee liabilities was not material to the consolidated financial statements and, therefore, no amounts were recorded at June 30, 2020 related to these guarantees. When THVG incurs guarantee obligations that are disproportionately greater than the guarantees provided by the investee's other owners, THVG charges the investee a fair market value fee based on the value of the contingent liability THVG is assuming.

Litigation and Professional Liability Claims

In their normal course of business, the Facilities are subject to claims and lawsuits relating to patient treatment. THVG believes that its liability for damages resulting from such claims and lawsuits is adequately covered by insurance or is adequately provided for in its consolidated financial statements. USPI, on behalf of THVG and each of the Facilities, maintains professional liability insurance that provides coverage on a claims-made basis of $1,000,000 per incident and $15,000,000 in annual aggregate amount with retroactive provisions upon policy renewal. USPI also purchases additional umbrella/excess policies. The limit of liability is an additional $25,000,000 annual aggregate. Certain of THVG's insurance policies have deductibles and contingent premium arrangements. Based on historical claims activity associated with litigation and professional liability matters, the Company believes its insurance coverage is appropriate and existing exposure related to known and incurred but not reported claims is negligible. Additionally, from time to time, THVG may be named as a party to other legal claims and proceedings in the ordinary course of business. THVG is not aware of any such claims or proceedings that have more than a remote chance of having a material adverse impact on THVG.

10. SUBSEQUENT EVENTS

During September and October 2020, the Department of Health and Human Services (HHS) issued updated reporting requirements significantly changing the previous guidance regarding utilization of the funds granted from the PRF under the CARES Act and other legislation. As a result of the updated guidance from HHS, the Company could be required to derecognize and return a portion of the original grant income recorded, which could be material to the Company. The Company is continuing to monitor the reporting requirements as they evolve.

Pursuant to federal legislation enacted on October 1, 2020, the Company expects the Centers for Medicare & Medicaid Services (CMS) recoupment of Medicare accelerated payments to begin in April 2021, extending into fiscal year 2022. As such, THVG expects the recoupments by CMS to extend beyond the next fiscal year, based on facts and circumstances that arose after the date of this report, June 30, 2020.

THVG regularly engages in exploratory discussions or enters into letters of intent with various entities regarding possible joint ventures, development, or other transactions. These possible joint ventures, developments of new facilities, or other transactions are in various stages of negotiation.

THVG has performed an evaluation of subsequent events through October 30, 2020, which is the date the consolidated financial statements were available to be issued. There have been no material subsequent events requiring financial statement disclosure after the balance sheet date.

DESCRIPTION OF SECURITIES
REGISTERED PURSUANT TO SECTION 12 OF
THE SECURITIES EXCHANGE ACT OF 1934

As of December 31, 2020, Tenet Healthcare Corporation (the "Company," "we," "our" or "us") has two classes of securities registered under Section 12 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"): (1) common stock; and (2) 6.875% Senior Notes due 2031 ("Senior Notes").

Description of Common Stock

The following description of our common stock is a summary and does not purport to be complete. It is subject to and qualified in its entirety by reference to our Amended and Restated Articles of Incorporation (the "Articles of Incorporation") and our Amended and Restated Bylaws (the "Bylaws"), each of which is incorporated by reference as an exhibit to the Annual Report on Form 10-K of which this Exhibit 4(a) is a part. We encourage you to read our Articles of Incorporation, our Bylaws and the applicable provisions of Chapter 78 of the *Nevada Revised Statutes*, for additional information.

Authorized Capital Shares

Our authorized capital shares consist of 1,050,000,000 shares of common stock, $0.05 par value, and 2,500,000 shares of preferred stock, $0.15 par value. Outstanding shares of our common stock are not subject to redemption and are non-assessable.

Voting Rights

Holders of our common stock are entitled to one vote per share on all matters voted on by the stockholders, including the election of directors. Our common stock does not have cumulative voting rights. The affirmative vote of a majority of the holders of all outstanding shares, voting together and not by class, is required to approve any merger or consolidation or the sale of substantially all of our assets.

Special Meetings

Special meetings of the stockholders, for any purpose or purposes whatsoever, (a) may be called at any time by the Chairman of the board, the Chief Executive Officer, or the board of directors, and (b) shall be called by the Secretary of the Company upon the written request of one or more stockholders having Net Long Beneficial Ownership (as defined in the Bylaws) of at least 25% of all outstanding shares of our common stock.

Dividend Rights

From time to time, our board of directors may declare, and we may pay, dividends or other distributions on our outstanding shares in the manner and on the terms and conditions provided by the laws of the State of Nevada and the Articles of Incorporation, subject to any contractual restrictions to which we are then subject.

Liquidation Rights

In the event of a liquidation, dissolution or winding-up of our company, holders of common stock are entitled to share equally and ratably in the assets of our company, if any, remaining after the payment of all debts and liabilities of our company and the liquidation preference of any outstanding preferred stock.

Amendments to Bylaws

Subject to the right of the stockholders to adopt, amend or restate, or repeal the Bylaws, our board of directors may adopt, amend or repeal any of the Bylaws, except as otherwise provided in the Bylaws, by the affirmative vote of a majority of directors.

Advance Notice Requirements

The Bylaws establish advance notice procedures with regard to stockholder proposals relating to the nomination of candidates for election as directors or other business to be brought before meetings of our stockholders. These procedures provide that notice of stockholder proposals of these kinds must be timely given in writing to the Secretary of the Company before the meeting at which the action is to be taken. Generally, to be timely, a stockholder's notice to the Secretary must be delivered to or mailed and received at the Company's corporate headquarters by the close of business not less than 90 days nor more than 120 days prior to the anniversary date of the immediately preceding annual meeting of stockholders; provided, however, that in the event that the annual meeting is called for a date that is not within 30 days before or after such anniversary date, or if no annual meeting was held in the preceding year, notice by the stockholder in order to be timely must be so received not later than the close of business on the tenth day following the day on which the Company makes a public announcement of the date of the annual meeting. The notice must contain certain information specified in the Bylaws.

Written Consent by Stockholders

Any action that may be taken at any meeting of the stockholders, except election or removal of directors, may be taken without a meeting only if authorized by a writing signed by stockholders owning all of the shares of common stock entitled to vote on the action.

Other Rights and Preferences

The holders of our common stock do not have any conversion or subscription rights, and their preemptive rights are limited as provided under Nevada law. The rights, preferences and privileges of holders of our common stock are subject to any series of preferred stock that we may issue in the future.

Listing; Transfer Agent

Our common stock is listed on New York Stock Exchange ("NYSE") under the trading symbol "THC". Our transfer agent and registrar is Computershare.

Description of the Senior Notes

General

The Senior Notes were issued pursuant to an Indenture, dated as of November 6, 2001 (the "Base Indenture"), as supplemented with respect to the Senior Notes by the Third Supplemental Indenture, dated as of November 6, 2001 (the "Supplemental Indenture" and, together with the Base Indenture, the "Indenture"), between us and The Bank of New York Mellon Trust Company, N.A., as successor to The Bank of New York, as trustee. Each of the Base Indenture and the Supplemental Indenture is incorporated by reference as an exhibit to the Annual Report on Form 10-K of which this Exhibit 4(a) is a part. The terms of the Senior Notes include those stated in the Indenture and those made part of the Indenture by reference to the Trust Indenture Act of 1939, as amended. The Senior Notes are subject to all such terms, and you should refer to the Indenture and the Trust Indenture Act for a statement thereof. The following description of the Senior Notes is a summary and does not purport to be complete. It is subject to and qualified in its entirety by reference to the Indenture, including the definitions therein of terms used below. As used in this "Description of the Senior Notes," the terms the "Company," "we," "our" and "us" refer to Tenet Healthcare Corporation and not to any of our subsidiaries.

The Senior Notes have been issued in fully registered form, in denominations of $1,000 and integral multiples thereof, registered in the name of Cede & Co., a nominee of The Depository Trust Company, or DTC. See "—Global Notes" below. The paying agent, registrar and transfer agent for the Senior Notes will be the corporate trust department of the trustee in New York, New York. Payment of principal will be made at maturity in immediately payable funds against surrender to the trustee.

We may from time to time, without giving notice to or seeking the consent of the holders of the Senior Notes, issue notes having the same ranking and the same interest rate, maturity and other terms as the Senior Notes. Any additional notes having such similar terms, together with the Senior Notes previously outstanding, will constitute a single series of notes under the Indenture.

Principal Amount; Maturity

The Senior Notes were offered in the aggregate principal amount of $450 million and have a maturity date of November 15, 2031. At December 31, 2020, $362 million aggregate principal amount of the Senior Notes remains outstanding.

Interest

Interest on the Senior Notes accrues at a rate of 6.875% per annum and is payable semi-annually in arrears on May 15 and November 15 of each year to holders of record on the immediately preceding May 1 and November 1. Payments commenced on May 15, 2002. Interest on the Senior Notes accrues from the most recent date to which interest has been paid.

Interest on the Senior Notes is computed on the basis of a 360-day year comprised of twelve 30-day months. Principal, premium, if any, and interest on the Senior Notes is payable at our office or agency maintained for such purpose within the City and State of New York or, at our option, payment of interest may be made by check mailed to the holders of the Senior Notes at their respective addresses set forth in the register of holders of the Senior Notes; provided that all payments with respect to Senior Notes as to which the holders have given wire transfer instructions to the paying agent on or prior to the relevant record date will be required to be made by wire transfer of immediately available funds to the accounts specified by such holders. Until otherwise designated by us, our office or agency in New York will be the office of the trustee maintained for such purpose.

Optional Redemption

The Senior Notes are redeemable, in whole or in part, at any time, at our option, at a redemption price equal to the greater of:

- 100% of the principal amount of the Senior Notes being redeemed, or
- the sum of the present values of the remaining scheduled payments of principal and interest thereon, excluding accrued and unpaid interest to the date of redemption, discounted to the redemption date on a semi-annual basis (assuming a 360-day year consisting of twelve 30-day months), at the Adjusted Treasury Rate, plus 35 basis points,

plus, in either of the above cases, accrued and unpaid interest thereon to, but not including, the redemption date. The Senior Notes will not be subject to any mandatory sinking fund.

"Adjusted Treasury Rate" means, with respect to any redemption date:

- the yield, under the heading that represents the average for the immediately preceding week, appearing in the most recently published statistical release designated "H.15(519)" or any successor publication that is published weekly by the Board of Governors of the Federal Reserve System and that establishes yields on actively traded United States Treasury securities adjusted to constant maturity under the caption "Treasury Constant Maturities," for the maturity corresponding to the Comparable Treasury Issue (if no maturity is within three months before or after the Remaining Life, yields for the two published maturities most closely corresponding to the Comparable Treasury Issue shall be determined and the Adjusted Treasury Rate shall be interpolated or extrapolated from such yields on a straight line basis, rounded to the nearest month); or

- if such release (or any successor release) is not published during the week preceding the calculation date or does not contain such yields, the rate per annum equal to the semi-annual equivalent yield to maturity of the Comparable Treasury Issue, calculated using a price for the Comparable Treasury Issue (expressed as a percentage of its principal amount) equal to the Comparable Treasury Price for such redemption date.

The Adjusted Treasury Rate shall be calculated on the third business day preceding the redemption date.

"Comparable Treasury Issue" means the United States Treasury security selected by an Independent Investment Banker as having a maturity comparable to the remaining term of the Senior Notes to be redeemed that would be utilized, at the time of selection and in accordance with customary financial practice, in pricing new issues of corporate debt securities of comparable maturity to the remaining term of those Senior Notes ("Remaining Life").

"Comparable Treasury Price" means, with respect to any redemption date, (1) the average of five Reference Treasury Dealer Quotations for such redemption date, after excluding the highest and lowest Reference Treasury Dealer Quotations, or (2) if the Independent Investment Banker obtains fewer than five such Reference Treasury Dealer Quotations, the average of all such quotations.

"Independent Investment Banker" means one of the Reference Treasury Dealers appointed by us.

"Reference Treasury Dealer" means:

- each of Credit Suisse Securities (USA) LLC, Citigroup Global Markets Inc. and J.P. Morgan Securities LLC and their respective successors; provided that, if any of the foregoing ceases to be a primary U.S. Government securities dealer in New York City (a "Primary Treasury Dealer"), we will substitute another Primary Treasury Dealer; and

- any other Primary Treasury Dealer selected by us.

"Reference Treasury Dealer Quotation" means, with respect to each Reference Treasury Dealer and any redemption date, the average, as determined by the Independent Investment Banker, of the bid and asked prices for the Comparable Treasury Issue (expressed in each case as a percentage of its principal amount) quoted in writing to the Independent Investment Banker by such Reference Treasury Dealer at 5:00 p.m., New York City time, on the third business day preceding such redemption date.

If less than all of the Senior Notes are to be redeemed at any time, selection of notes for redemption will be made by the trustee in compliance with the requirements of the principal national securities exchange, if any, on which the notes to be redeemed are then listed, or, if the Senior Notes are not so listed, on a pro rata basis, by lot or by such method as the trustee deems fair and appropriate; provided that notes with a principal amount of $1,000 will not be redeemed in part.

We will mail a notice of redemption at least 30 but not more than 60 days before the redemption date to each holder of the Senior Notes to be redeemed. If the Senior Notes are to be redeemed in part only, the notice of redemption

that relates to such notes will state the portion of the principal amount thereof to be redeemed. A new note in principal amount equal to the unredeemed portion thereof will be issued in the name of the holder thereof upon cancellation of the original note.

Unless we default in payment of the redemption price, on and after the redemption date, interest will cease to accrue on the Senior Notes or portions thereof called for redemption.

Priority

The Base Indenture does not limit the aggregate principal amount of debt securities that may be issued thereunder. As permitted under the terms of the Base Indenture, we have issued, and may in the future issue, other debt securities under the Base Indenture constituting one or more separate series. The Senior Notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other existing and future unsecured senior indebtedness, but are effectively subordinated to our senior secured notes, the obligations of our subsidiaries and any obligations under our credit facilities to the extent of the value of the collateral.

Limitations on Us and Our Subsidiaries

Limitations on Liens. The Indenture provides that, except as described under "—Exception to Limitations" below, neither we nor any of our subsidiaries will issue, incur, create, assume or guarantee any debt secured by liens, mortgages, pledges, charges, security interests or other encumbrances upon any principal property (which means each of our hospitals that has a book value in excess of 5% of our consolidated net tangible assets), unless the Senior Notes will be secured equally and ratably with, or prior to, such debt. This restriction will not apply to:

- liens securing the purchase price or cost of construction of property or additions, substantial repairs, alterations or improvements, if the debt and the liens are incurred within 12 months of the acquisition, the completion of construction and full operation or the completion of such additions, repairs, alterations or improvement;

- liens existing on property at the time of its acquisition by us or our subsidiaries or on the property of an entity at the time of the acquisition of such entity by us or our subsidiaries, provided that the liens were in existence prior to the closing of, and not incurred in contemplation of, such acquisition and, in the case of the acquisition of an entity, the liens do not extend to any assets other than those of the entity acquired;

- liens in favor of us or a consolidated subsidiary;

- liens existing on the date of the Supplemental Indenture;

- certain liens to governmental entities;

- liens incurred within 90 days (or any longer period, not in excess of one year, as permitted by law), after acquisition of the related property arising solely in connection with the transfer of tax benefits in accordance with Section 168(f)(8) of the Internal Revenue Code;

- any substitution or replacement of any lien referred to above, provided that the property encumbered by any substitute or replacement lien is substantially similar in nature to and no greater in value than the property encumbered by the lien that is being replaced; and

- any extension, renewal or replacement of any lien referred to above, provided the amount secured is not increased and it relates to the same property.

Limitations on Sale and Lease-Back Transactions. The Indenture provides that, except as described under "—Exception to Limitations" below, neither we nor any of our subsidiaries will enter into any sale and lease-back transaction with respect to any principal property with another person, other than us or one of our consolidated subsidiaries, unless:

- we or any of our subsidiaries could incur debt secured by a lien on the property to be leased without securing the Senior Notes;
- the lease is for three years or less; or
- within 120 days, we apply the greater of the net proceeds of the sale of the leased property or the fair value of the leased property to the acquisition, construction, addition, repair, alteration or improvement of a principal property or the voluntary retirement of our long-term debt.

Exception to Limitations. Notwithstanding the two covenants described above, we and any of our subsidiaries may issue, incur, create, assume or guarantee debt secured by liens or enter into any sale and lease-back transaction that would otherwise be subject to the restrictions on liens and sale and lease-back transactions described above, provided that (i) the aggregate amount of all our debt subject to the restriction on liens described above plus (ii) the aggregate attributable debt in respect of sale and lease-back transactions that is subject to the restriction on sale and lease-back transactions above, does not exceed 15% of our consolidated net tangible assets.

Consolidation, Merger and Sale of Assets. The Indenture provides that we may not consolidate with, or sell, convey or lease all or substantially all of our properties and assets to, or merge with or into, any other person, unless:

- we are the surviving corporation or the successor is a corporation organized and validly existing under the laws of any U.S. domestic jurisdiction and expressly assumes the due and punctual payment of the principal of and interest on all the Senior Notes and the due and punctual performance and observation of our covenants and obligations under the Indenture; and
- immediately after giving effect to the transaction, no event of default, and no event which, after notice or lapse of time or both would become an event of default has occurred and is continuing under the Indenture.

Events of Default

Under the Indenture, each of the following constitutes an event of default with respect to the Senior Notes:

- failure to pay the principal of or premium, if any, on the Senior Notes, at maturity or otherwise;
- failure to pay any interest on the Senior Notes when due, continued for 30 days;
- failure to perform, or the breach of, any of our covenants or warranties in the Indenture or the Senior Notes, continued for 90 days after written notice; or
- events of bankruptcy, insolvency or reorganization with respect to us.

In addition to the events of default set forth above, an event of default will be deemed to have occurred with respect to the Senior Notes the event of a failure to pay at maturity or the acceleration of our indebtedness having an aggregate principal amount in excess of the greater of $25 million or 5% of our consolidated net tangible assets under the terms of the instrument under which that indebtedness is issued or secured if that indebtedness is not discharged or the acceleration is not annulled within 10 days after written notice.

If any event of default with respect to the Senior Notes occurs and is continuing, either the trustee or the holders of at least 25% in principal amount of the Senior Notes then outstanding, by written notice to us and to the trustee, may declare the principal amount of the Senior Notes to be due and payable immediately. Notwithstanding the foregoing, in the case of an event of default arising from certain events of bankruptcy, insolvency or reorganization, all outstanding Senior Notes will automatically and without any action by the trustee or any holder, become immediately due and payable. After any such acceleration, but before a judgment or decree based on such acceleration, the holders of a majority in aggregate principal amount of the Senior Notes then outstanding may, under certain circumstances, rescind and annul such acceleration if all events of default, other than the non-payment of accelerated principal of or interest on the Senior Notes, have been cured or waived as provided in the Indenture.

Subject to the provisions of the Indenture relating to the duties of the trustee in case an event of default occurs and is continuing, the trustee will be under no obligation to exercise any of its rights or powers under the Indenture at the request or direction of any of the holders, unless such holders have offered to the trustee reasonable indemnity. Subject to such provisions for the indemnification of the trustee, the holders of a majority in aggregate principal amount of Senior Notes then outstanding will have the right to direct the time, method and place of conducting any proceedings for any remedy available to the trustee or exercising any trust or power conferred on the trustee with respect to the Senior Notes.

No holder of a Senior Note will have any right to institute any proceeding with respect to the Indenture, or for the appointment of a receiver or a trustee, or for any other remedy thereunder, unless:

- such holder has previously given the trustee written notice of a continuing event of default with respect to the Senior Notes;
- the holders of at least 25% in the aggregate principal amount of the Senior Notes then outstanding have made written request, and such holder or holders have offered reasonable indemnity, to the trustee to institute such proceedings as trustee; and
- the trustee has failed to institute such proceeding and the trustee has not received from the holders of a majority in aggregate principal amount of the Senior Notes then outstanding a direction inconsistent with such request within 60 days after such notice, request and offer.

Such limitations, however, do not apply to a suit instituted by a holder of a Senior Note for the enforcement of payment of the principal of or interest on such Senior Note on or after its due date.

Defeasance and Covenant Defeasance

We may elect, at our option at any time, to have the provisions of the Indenture relating to defeasance and discharge of indebtedness and to defeasance of certain restrictive covenants applied to the Senior Notes.

Defeasance and Discharge. The Indenture provides that, upon the exercise of our option, we will be discharged from all our obligations with respect to Senior Notes (except for certain obligations to exchange or register the transfer of notes, to replace stolen, lost or mutilated notes, to maintain paying agencies and to hold moneys for payment in trust), subject to the conditions precedent below.

Defeasance of Certain Covenants. The Indenture provides that, upon the exercise of our option with respect to the Senior Notes, we may omit to comply with certain restrictive covenants, including those described under
"—Limitations on Us and Our Subsidiaries" above, and the occurrence of certain events of default will be deemed not to be or result in an event of default, in each case with respect to the Senior Notes, subject to the conditions precedent below.

In each case, the defeasance provision will be subject to our depositing in trust for the benefit of the holders of the Senior Notes to be defeased money or U.S. government obligations, or both, which, through the payment of

principal and interest in respect thereof in accordance with their terms, will provide money in an amount sufficient to pay the principal of and any premium and interest on such notes on the stated maturity in accordance with the terms of the Indenture and the Senior Notes. We will also be required, among other things, to deliver to the trustee an opinion of counsel to the effect that holders of such notes will not recognize gain or loss for federal income tax purposes as a result of such deposit, defeasance and discharge and will be subject to federal income tax on the same amount, in the same manner and at the same times as would have been the case if such deposit, defeasance and discharge were not to occur.

In the event we exercised this option with respect to any Senior Notes and such notes were declared due and payable because of the occurrence of any event of default, the amount of money and U.S. government obligations so deposited in trust would be sufficient to pay amounts due on such notes at the time of their respective stated maturities but may not be sufficient to pay amounts due on such notes upon any acceleration resulting from such event of default. In such case, we would remain liable for such payments.

Amendment, Supplement and Waiver

Except as provided in the next two succeeding paragraphs, the Indenture or the Senior Notes may be amended or supplemented with the consent of the holders of at least a majority in principal amount of the Senior Notes then outstanding (including consents obtained in connection with a tender offer or exchange offer for such notes), and any existing default or compliance with certain restrictive provisions of the Indenture may be waived with the consent of the holders of a majority in principal amount of the then outstanding Senior Notes (including consents obtained in connection with a tender offer or exchange offer for such notes).

Without the consent of each holder affected, an amendment or waiver may not (with respect to any Senior Notes held by a non-consenting holder):

- reduce the principal of or change the fixed maturity of any Senior Note;
- reduce the rate of or change the time for payment of interest on any Senior Note;
- waive a default or event of default in the payment of principal of or premium, if any, or interest on the Senior Notes (except a rescission of acceleration of the applicable notes by the holders of at least a majority in aggregate principal amount thereof and a waiver of the payment default that resulted from such acceleration);
- change the place of payment of any Senior Note or make any Senior Note payable in money other than that stated in such note;
- impair the right to institute suit for the enforcement of any payment on or with respect to any Senior Note;
- make any change in the provisions of the Indenture relating to waivers of past defaults or the rights of holders of Senior Notes to receive payments of principal of or premium, if any, or interest on such notes;
- reduce the principal amount of Senior Notes whose holders must consent to an amendment, supplement or waiver; or
- make any change in the foregoing amendment and waiver provisions, except to increase the required percentage or to provide that other provisions of the Indenture cannot be modified or waived without the consent of the holder of each outstanding Senior Note.

Notwithstanding the foregoing, without the consent of any holder of Senior Notes, we, together with the trustee, may amend or supplement the Indenture to:

- cure any ambiguity, defect or inconsistency, provided that such action does not adversely affect the holders in any material respect;
- provide for uncertificated notes in addition to or in place of certificated notes;
- evidence the assumption of our obligations to holders of Senior Notes in the case of a merger, consolidation or sale of assets pursuant to the covenant described under the caption "—Limitations on Us and Our Subsidiaries—Consolidation, Merger and Sale of Assets";
- add covenants for the benefit of the holders of the Senior Notes or to surrender any right or power conferred upon us;
- make any change that does not adversely affect the legal rights under the Indenture of any such holder in any material respect;
- add any additional events of default for the benefit of the holders of the Senior Notes;
- secure the Senior Notes;
- establish the form or terms of other series of debt securities as permitted under the Indenture;
- comply with requirements of the Securities and Exchange Commission in order to effect or maintain the qualification of the Indenture under the Trust Indenture Act; or
- appoint a successor trustee.

Except in certain limited circumstances, we will be entitled to set any day as a record date for the purpose of determining the holders of Senior Notes entitled to give or take any direction, notice, consent, waiver or other action or to vote on any action under the Indenture, in the manner and subject to the limitations provided in the Indenture. In certain limited circumstances, the trustee will be entitled to set a record date for action by holders. If a record date is set for any action to be taken by holders, such action may be taken only by persons who are holders of outstanding Senior Notes on the record date. To be effective, the action must be taken by holders of the requisite principal amount of the Senior Notes within a specified period following the record date. For any particular record date, this period will be 180 days or such shorter period as may be specified by us (or the trustee, if it set the record date), and may be shortened or lengthened from time to time, but not beyond 180 days.

The Trustee

The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, is the trustee under the Indenture. The corporate trust office of the trustee is located in New York, New York.

We maintain banking relations with affiliates of The Bank of New York Mellon Trust Company, N.A. The Bank of New York Mellon Trust Company, N.A. has also served from time to time as escrow agent under escrow agreements to which we are party. In addition, The Bank of New York Mellon Trust Company, N.A. is the trustee under other indentures pursuant to which we have issued debt. Pursuant to the Trust Indenture Act of 1939, as amended, should a default occur with respect to the Senior Notes, the trustee would be required to eliminate any conflicting interest as defined in the Trust Indenture Act of 1939, as amended, or resign as trustee with respect to the Senior Notes within 90 days of such default unless such default were cured, duly waived or otherwise eliminated.

The trustee may resign at any time or may be removed by us. If the trustee resigns, is removed or becomes incapable of acting as trustee or if a vacancy occurs in the office of the trustee for any cause, a successor trustee shall be appointed in accordance with the provisions of the Indenture. The Indenture provides that in case an event of default occurs (and is not cured), the trustee will be required, in the exercise of its power, to use the degree of care of a prudent man in the conduct of his own affairs. Subject to such provisions, the trustee will be under no obligation to exercise any of its rights or powers under the Indenture at the request of any holder of Senior Notes, unless such holder has offered to the trustee security and indemnity satisfactory to it against any loss, liability or expense.

Global Notes

The Senior Notes have been issued in the form of one or more registered notes in book-entry form, referred to as global notes. Each such global note is registered in the name of a nominee of DTC, as depositary, and has been deposited with The Bank of New York Mellon Trust Company, N.A., as custodian therefor. Interest in each such global note is not exchangeable for certificated notes in definitive, fully registered form, except in the limited circumstances described below. We will be entitled, along with the trustee and any other agent, to treat DTC or its nominee, as the case may be, as the sole owner and holder of the global notes for all purposes.

So long as DTC or its nominee or a common depositary is the registered holder of a global note, DTC or such nominee or common depositary, as the case may be, will be considered the sole owner and holder of such global note, and of the Senior Notes represented thereby, for all purposes under the Indenture and the Senior Notes and the beneficial owners of Senior Notes will be entitled only to those rights and benefits afforded to them in accordance with DTC's regular operating procedures. Upon specified written instructions of a DTC participant, DTC will have its nominee assist its participants in the exercise of certain holders' rights, such as a demand for acceleration or an instruction to the trustee. Except as provided below, owners of beneficial interests in a global note will not be entitled to have Senior Notes represented by a global note registered in their names, will not receive or be entitled to receive physical delivery of Senior Notes in certificated form and will not be considered the registered holders thereof under the Indenture.

Ownership of beneficial interests in a global note will be limited to DTC participants or persons who hold interests through DTC participants. Ownership of beneficial interests in a global note is shown on, and the transfer of those ownership interests are effected through, records maintained by DTC or its nominee (with respect to interests of participants) or by any such participant (with respect to interests of persons held by such participants on their behalf). Payments, transfers, exchanges and other matters relating to beneficial interests in a global note may be subject to various policies and procedures adopted by DTC from time to time. None of the Company, the trustee or any of their agents will have any responsibility or liability for any aspect of DTC's or any DTC participant's records relating to, or for payments made on account of, beneficial interest in any global note, or for maintaining, supervising or reviewing any records relating to such beneficial interests.

Interests in a global note will be exchanged for Senior Notes in certificated form if:

- DTC notifies us that it is unwilling or unable to continue as a depositary for such global note or has ceased to be qualified to act as such or if at any time such depositary ceases to be a clearing agency registered under the Exchange Act, and we have not appointed a successor depositary within 90 days;
- an event of default under the Indenture with respect to the Senior Notes has occurred and is continuing; or
- we, in our sole discretion, determine at any time that the Senior Notes will no longer be represented by a global note.

Upon the occurrence of such an event, owners of beneficial interests in such global note will receive physical delivery of Senior Notes in certificated form. All certificated notes issued in exchange for an interest in a global note or any portion thereof will be registered in such names as DTC directs. Such notes will be issued in minimum denominations of $1,000 and integral multiples thereof and will be in registered form only, without coupons.

No beneficial owner of an interest in a global note will be able to transfer that interest except in accordance with DTC's applicable procedures, in addition to those under the Indenture and the Senior Notes.

Investors may hold their interest in a global note directly through DTC if they are participants or indirectly through organizations that are DTC participants. Accordingly, although owners who hold Senior Notes through DTC participants will not possess notes in definitive form, the participants provide a mechanism by which holders of Senior Notes will receive payments and will be able to transfer their interests.

The holder of a certificated note may transfer such note, subject to compliance with the provisions of such legend, by surrendering it at (i) the office or agency maintained by us for such purpose in the Borough of Manhattan, The City of New York, which initially will be the office of the trustee maintained for such purpose or (ii) the office of any transfer agent we appoint.

We will make all payments of principal and interest on the Senior Notes in immediately available funds so long as the Senior Notes are maintained in the form of global notes.

Governing Law

The Indenture and the Senior Notes provide that they are governed by, and interpreted in accordance with, the internal laws of the State of New York.

Listing

The Senior Notes are listed on the NYSE under the trading symbol “THC31”.

Exhibit 10(hh)

TENET

FIFTH AMENDED AND RESTATED

EXECUTIVE SEVERANCE PLAN

As Amended and Restated Effective February 1, 2021

FIFTH AMENDED AND RESTATED
EXECUTIVE SEVERANCE PLAN

TABLE OF CONTENTS

FIFTH AMENDED AND RESTATED
EXECUTIVE SEVERANCE PLAN

ARTICLE I
PREAMBLE AND PURPOSE

1.1 Preamble. Tenet Healthcare Corporation (the "**Company**") has adopted this Tenet Fifth Amended and Restated Executive Severance Plan (the "**ESP**") effective as of February 1, 2021. The ESP was formerly known as the Tenet Executive Severance Protection Plan (the "**TESPP**") when it was first adopted in January 2003 and was previously amended and restated on May 11, 2006, December 31, 2008, May 9, 2012, August 8, 2018.

The Company intends that the ESP comply with the requirements of Section 409A of the Internal Revenue Code of 1986, as amended (the "**Code**") to the extent applicable.

The Company may adopt one or more domestic trusts to serve as a possible source of funds for the payment of benefits under the ESP.

1.2 Purpose. Through the ESP, the Company intends to permit the deferral of compensation and to provide additional benefits to a select group of management or highly compensated employees of the Company and its affiliates. Accordingly, it is intended that the ESP will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Code, nor will it constitute a "funded plan," for purposes of such requirements. It also is intended that the ESP will qualify as a "pension plan" within the meaning of section 3(2) of the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**") that is exempt from the participation and vesting requirements of Part 2 of Title I of ERISA, the funding requirements of Part 3 of Title I of ERISA, and the fiduciary requirements of Part 4 of Title I of ERISA by reason of the exclusions afforded plans that are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

.1 **Definitions.** When a word or phrase appears in this ESP with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) "**Affiliate**" means a corporation that is a member of a controlled group of corporations (as defined in section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is in common control (as defined in section 414(c) of the Code) with the Company, or any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company.

(b) "**AIP**" means the Company's Annual Incentive Plan, as the same may be amended, restated, modified, renewed or replaced from time to time.

(c) "**Average Bonus**" means the average company performance bonus percent applicable to the Covered Executive under the AIP for the three years (or actual period of employment, if less) preceding the year of his Qualifying Termination (subject to a fifty percent (50%) minimum) multiplied by his Base Salary at the time of a Qualifying Termination.

(d) '**Base Salary**" means the Covered Executive's annual gross rate of pay including amounts reduced from the Employee's compensation and contributed on the Employee's behalf as deferrals under any qualified or non-qualified employee benefit plans sponsored by the Employer in effect immediately before a Qualifying Termination. Base Salary **excludes** bonuses, hardship withdrawal allowances, AIP awards, housing allowances, relocation payments, deemed income, income payable under the SIP or other stock incentive plans, holiday gifts, insurance premiums and other imputed income, pensions, and retirement benefits.

(e) "**Board**" means the Board of Directors of the Company.

(f) "**Bonus**" means the amount payable to a Covered Executive, if any, under the AIP.

(g) "**Cause**" means

(i) when used in connection with a Qualifying Termination triggering benefits pursuant to Section 3.1, a Covered Executive's:

(A) dishonesty,

(B) fraud,

(C) willful misconduct,

(D) breach of fiduciary duty,

(E) conflict of interest,

(F) commission of a felony,

(G) material failure or refusal to perform his job duties in accordance with Company policies,

(H) a material violation of Company policy that causes harm to the Company or an Affiliate, or

(I) with respect to Covered Executives who are first hired or promoted into a Tier I or Tier II Covered Position on and after the Effective Date (i.e., who were not participants before such employment or promotion), a failure to improve work performance to an acceptable level after the Covered Executive was warned in writing and provided a framework for improvement over a reasonable period of time; or

(J) other wrongful conduct of a similar nature and degree.

Except with respect to Covered Executives who are first hired or promoted into a Tier I or Tier II Covered Position on and after the Effective Date (i.e., who were not participants before such employment or promotion), a failure to meet or achieve business objectives, as defined by the Company, will not be considered Cause so long as the Covered Executive has devoted his best efforts and attention to the achievement of those objectives

(ii) when used in connection with a Qualifying Termination triggering benefits pursuant to Section 3.2:

(A) any intentional act or misconduct materially injurious to the Company or any Affiliate, financial or otherwise, but not limited to, misappropriation or fraud, embezzlement or conversion by the Covered Executive of the Company's or any Affiliate's property in connection with the Covered Executive's employment with the Company or an Affiliate,

(B) Any willful act or omission constituting a material breach by the Covered Executive of a fiduciary duty,

(C) A final, non-appealable order in a proceeding before a court of competent jurisdiction or a final order in an administrative proceeding finding that the Covered Executive committed any willful misconduct or criminal activity (excluding minor traffic violations or other minor offenses), which commission is materially inimical to the interests of the Company or any Affiliate, whether

for his personal benefit or in connection with his duties for the Company or an Affiliate,

(D) The conviction (or plea of no contest) of the Covered Executive for any felony,

(E) Material failure or refusal to perform his job duties in accordance with Company policies (other than resulting from the Covered Executive's disability as defined by Company policies), or

(F) A material violation of Company policy that causes material harm to the Company or an Affiliate.

A failure to meet or achieve business objectives, as defined by the Company, will not be considered Cause so long as the Covered Executive has devoted his reasonable efforts and attention to the achievement of those objectives. For purposes of this Section, no act or failure to act on the part of the Covered Executive will be deemed "willful", "intentional" or "knowing" if it was undertaken in reasonable reliance on the advice of counsel or at the instruction of the Company, including but not limited to the Board, a committee of the Board or the Chief Executive Officer ("**CEO**") of the Company, or was due primarily to an error in judgment or negligence, but will be deemed "willful", "intentional" or "knowing" only if done or omitted to be done by the Covered Executive not in good faith and without reasonable belief that the Covered Executive's action or omission was in the best interest of the Company.

(iii) A Covered Executive will not be deemed to have been terminated for Cause, under either Section 2.1(g)(i) or 2.1(g)(ii) above, as applicable, unless and until there has been delivered to the Covered Executive written notice that the Covered Executive has engaged in conduct constituting Cause. A Covered Executive who receives written notice that he has engaged in conduct constituting Cause, will be given the opportunity to be heard (either in person or in writing as mutually agreed to by the Covered Executive and the Human Resources Committee, CEO or COO, as applicable) for the purpose of considering whether Cause exists. If it is determined either at or following such hearing that Cause exists, the Covered Executive will be notified in writing of such determination within five (5) business days. If the Covered Executive disagrees with such determination, the Covered Executive may file a claim contesting such determination pursuant to Article IV within thirty (30) days after his receipt of such written determination finding that Cause exists.

(h) "**Change of Control**" means the occurrence of one of the following:

(i) A "change in the ownership of the Company" which will occur on the date that any one person, or more than one person acting as a group within the meaning of section 409A of the Code, acquires, directly or indirectly,

whether in a single transaction or series of related transactions, ownership of stock in the Company that, together with stock held by such person or group, constitutes more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company ("**Ownership Control**"). However, if any one person or more than one person acting as a group, has previously acquired ownership of more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company, the acquisition of additional stock by the same person or persons will not be considered a "change in the ownership of the Company" (or to cause a "change in the effective control of the Company" within the meaning of Section 2.1(h)(ii) below). Further, an increase in the effective percentage of stock owned by any one person, or persons acting as a group, as a result of a transaction in which the Company acquires its stock in exchange for cash or property will be treated as an acquisition of stock for purposes of this paragraph; provided, that for purposes of this Section 2.1(h)(i), the following acquisitions of Company stock will not constitute a Change of Control:

(A) any acquisition, whether in a single transaction or series of related transactions, by any employee benefit plan (or related trust) sponsored or maintained by the Company or an Affiliate which results in such employee benefit plan obtaining "Ownership Control" of the Company;

(B) any acquisition, whether in a single transaction or series of related transactions, by the Company which results in the Company acquiring stock of the Company representing "Ownership Control"; or

(C) any acquisition, whether in a single transaction or series of related transactions, after which those persons who were owners of the Company's stock immediately before such transaction(s) own more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company (or if after the consummation of such transaction(s) the Company (or another entity into which the Company is merged into or otherwise combined, such the Company does not survive such transaction(s)) is a direct or indirect subsidiary of another entity which itself is not a subsidiary of an entity, then the more than fifty percent (50%) ownership test will be applied to the voting securities of such other entity) in substantially the same percentages as their respective ownership of the Company immediately before such transaction(s).

This Section 2.1(h)(i) applies either when there is a transfer of the stock of the Company (or issuance of stock) and stock in the Company remains outstanding after the transaction or when there is a transfer of the stock of the Company (including a merger or similar transaction) and stock in the Company does not remain outstanding after the transaction.

(ii) A "change in the effective control of the Company" which will occur on the date that either (A) or (B) occurs:

(A) any one person, or more than one person acting as a group within the meaning of section 409A of the Code, acquires (taking into consideration any prior acquisitions during the twelve (12) month period ending on the date of the most recent acquisition by such person or persons), directly or indirectly, ownership of stock of the Company possessing thirty-five percent (35%) or more of the total voting power of the stock of the Company (not considering stock owned by such person or group before such twelve (12) month period) (*i.e.*, such person or group must acquire within a twelve (12) month period stock possessing at least thirty-five percent (35%) of the total voting power of the stock of the Company) ("**Effective Control**"), except for (i) any acquisition by any employee benefit plan (or related trust) sponsored or maintained by the Company or an Affiliate which results in such employee benefit plan obtaining "Effective Control" of the Company or (ii) any acquisition by the Company. The occurrence of "Effective Control" under this Section 2.1(h)(ii)(A) may be nullified by a vote of that number of the members of the Board that exceeds two-thirds (2/3) of the independent members of the Board, which vote must occur before the time, if any, that a "change in the effective control of the Company" has occurred under Section 2.1(h)(ii)(B) below. In the event of such a supermajority vote, such transaction or series of related transactions will not be treated as an event constituting "Effective Control". For avoidance of doubt, this ESP provides that in the event of the occurrence of the acquisition of ownership of stock of the Company that reaches or exceeds the thirty-five percent (35%) ownership threshold described above, if more than two-thirds (2/3) of the independent members of the Board take action to resolve that such an acquisition is not a "change in the effective control of the Company" and a majority of the members of the Board have not been replaced as provided under Section 2.1(h)(ii)(B) below, then such Board action will be final and no "Effective Control" will be deemed to have occurred for any purpose under the ESP.

(B) a majority of the members of the Board are replaced during any twelve (12) month period by directors whose appointment or election is not endorsed by a majority of the members of the Board before the date of the appointment or election.

For purposes of a "change in the effective control of the Company," if any one person, or more than one person acting as a group, is considered to effectively control the Company within the meaning of this Section 2.1(h)(ii), the acquisition of additional control of the Company by the same person or persons is not considered a "change in the effective control of

the Company," or to cause a "change in the ownership of the Company" within the meaning of Section 2.1(h)(i) above.

(iii) A sale, exchange, lease, disposition or other transfer of all or substantially all of the assets of the Company.
(iv) A liquidation or dissolution of the Company that is approved by a majority of the Company's stockholders.

For purposes of this Section 2.1(h), the provisions of section 318(a) of the Code regarding the constructive ownership of stock will apply to determine stock ownership; provided, that, stock underlying unvested options (including options exercisable for stock that is not substantially vested) will not be treated as owned by the individual who holds the option.

(i) "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(j) "**Code**" means the Internal Revenue Code of 1986, as amended from time to time and the regulations and rulings issued thereunder.

(k) "**Company**" means Tenet Healthcare Corporation and any successor thereto.

(l) "**Covered Executive**" means (i) any Employee hired or promoted on and after the Effective Date into the position of an Executive Vice President, Senior Vice President, Vice President, Hospital Chief Executive Officer or any similar roles or positions and who is designated by the HRC or the Tenet Chief Executive Officer ("**CEO**") or Chief Operating Officer ("**COO**") as a Tier I or Tier II Covered Executive and who enters into an ESP Agreement, (ii) any Employee who is designated as a Covered Executive by the Executive Vice President, Human Resources, the Plan Administrator or the Human Resources Committee and who enters into an ESP Agreement or (iii) an Employee who satisfied the definition of Covered Executive under the terms of a prior ESP document. The positions described above that are eligible to participate in the ESP are referred to as "**Covered Positions**."

(m) "**DCP**" means the Tenet 2001 Deferred Compensation Plan, the Tenet 2006 Deferred Compensation Plan and any other deferred compensation plan maintained by the Employer that covers Covered Executives.

(n) "**Effective Date**" means February 1, 2021.

(o) "**Employee**" means each select member of management or highly compensated employee receiving remuneration, or who is entitled to remuneration, for services rendered to the Employer, in the legal relationship of employer and employee. The term "Employee" does not include a consultant, independent contractor or leased employee even if such consultant, leased employee or independent contractor is subsequently determined by the Employer, the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a

common law employee of the Employer. Further, the term "Employee" does not include a person who is receiving severance pay from the Employer.

(p) "**Employer**" means the Company and each Affiliate that has adopted the ESP as a **participating** employer. Unless provided otherwise by the Human Resources Committee or the Board, all Affiliates will be participating employers in the ESP. Each such Affiliate may evidence its adoption of the ESP either by a formal action of its governing body or taking administrative actions with respect to the ESP on behalf of its Covered Executives (*e.g.*, communicating the terms of the ESP, etc.). An entity will automatically cease to be a participating employer as of the date such entity ceases to be an Affiliate.

(q) "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(r) "**ESP**" means the Tenet Executive Severance Plan as set forth herein and as the same may be amended from time to time. The ESP was formerly known as the TESPP.

(s) "**ESP Agreement**" means the written agreement between a Covered Executive and the Plan Administrator, on behalf of the Employer substantially in the form attached hereto in Appendix A. This form ESP Agreement may differ with respect to a Covered Executive who was covered under the terms of a prior ESP document or as determined by the Executive Vice President, Human Resources, Plan Administrator and/or Human Resources Committee, each in its sole and absolute discretion as provided in Section 3.6. Each ESP Agreement will form a part of the ESP with respect to the affected Covered Executive.

(t) "**Equity Plan**" means any equity plan, agreement or arrangement maintained or sponsored by the Employer other than the SIP.

(u) "**Five Percent Owner**" means any person who owns (or is considered as owning within the meaning of section 318 of the Code as modified by section 416(i)(1)(B)(iii) of the Code) more than five percent (5%) of the outstanding stock of the Company or an Affiliate or stock possessing more than five percent (5%) of the total combined voting power of all stock of the Company or an Affiliate. The rules of sections 414(b), (c) and (m) of the Code will not apply for purposes of applying these ownership rules. Thus, this ownership test will be applied separately with respect to the Company and each Affiliate.

(v) "**401(k) Plan**" means the Tenet Healthcare Corporation 401(k) Retirement Savings Plan or any other qualified retirement plan with a cash or deferred arrangement that is maintained or sponsored by the Employer.

(w) "**409A Exempt Amount**" means that portion of the distributions under the ESP to a Covered Executive that are not subject to the requirements of section 409A of the Code, including any amounts that qualify as a short-term deferral within the meaning of section 409A of the Code, and such amount that does not exceed two (2) times the **lesser** of:

(i) the sum of the Covered Executive's annualized compensation based upon the annual rate of pay for services provided to the Employer for the taxable year of the Covered Executive preceding the taxable year of the Covered Executive in which he has a Qualifying Termination, provided that such termination constitutes a "separation from service" with such Employer within the meaning of section 409A of the Code (adjusted for any increase during that year that was expected to continue indefinitely if the Covered Executive had not separated from service); or

(ii) the maximum amount that may be taken into account under a qualified plan pursuant to section 401(a)(17) of the Code for the year in which the Covered Executive has a Qualifying Termination, provided that such termination constitutes a "separation from service" within the meaning of section 409A of the Code.

In the event that a Covered Executive is a Key Employee, no distributions in excess of the 409A Exempt Amount will be made during the six (6) month period following the date of the Covered Executive's Qualifying Termination.

(x) "**Good Reason**" means:

(i) In the case of a voluntary termination of employment by a Covered Executive preceding or more than two (2) years following a Change of Control:

(A) a material diminution in the Covered Executive's job authority, responsibilities or duties;

(B) a material diminution of the Covered Executive's Base Salary;

(C) an involuntary and material change in the geographic location of the workplace at which the Covered Executive must perform services; or

(D) any other action or inaction that constitutes a material breach by the Employer or a successor of the agreement under which the Covered Executive provides services.

In the case of (B) above, such reduction will not constitute good reason if it results from a general across-the-board reduction for executives at a similar job level within the Employer.

(ii) In the case of a voluntary termination of employment by a Covered Executive upon or within two (2) years following a Change of Control:

(A) a material downward change in job functions, duties, or responsibilities which reduces the rank or position of the Covered Executive;

(B) a reduction in the Covered Executive’s Base Salary;

(C) a reduction in the aggregate value of the Covered Executive's Base Salary and Target Bonus;

(D) a material reduction in the Covered Executive's retirement or supplemental retirement benefits;

(E) an involuntary and material change in the geographic location of the workplace at which the Covered Executive must perform services; or

(F) any other action or inaction that constitutes a material breach by the Employer or a successor of the agreement under which the Covered Executive provides services.

During the period of two (2) years following a Change of Control, no adverse change may be made to a Covered Executive's (1) Base Salary, (2) Base Salary and Target Bonus in the aggregate, or (3) retirement or supplemental retirement benefits.

For avoidance of doubt, if the Covered Executive holds the title of Chief Executive Officer immediately before the occurrence of a Change of Control, in the event of the occurrence of a Change of Control in which the Covered Executive retains the same position with the Company, and any of the following events occur on or within two (2) years after the date of the Change of Control, such new role will be treated as a "material downward change in job functions, duties or responsibilities" within the meaning of Section 2.1(x)(ii)(A) above:

(1) Covered Executive ceases to be a member of the Board (or if the Company becomes directly or indirectly controlled by a Parent, Covered Executive does not become a member of the Board of Directors of such Parent);

(2) the Company either (A) ceases to have a class of equity securities that is actively traded on a national securities exchange or comparable public securities market or (B) becomes directly or indirectly controlled by a Parent and the Covered Executive does not serve as the Chief Executive Officer of such Parent; or

(3) Covered Executive is directed by the Board (or by a Parent, if the Company becomes directly or indirectly controlled by such Parent) to engage in an act or omission, which if performed would provide the Company with a basis for terminating Covered Executive for Cause.

(iii) If the Covered Executive believes that an event constituting Good Reason has occurred, in accordance with this Section 2.1(x)(i) or Section 2.1(x)(ii) above, as applicable, the Covered Executive must notify the Plan Administrator of that belief within ninety (90) days following the

occurrence of the Good Reason event, which notice will set forth the basis for that belief. The Plan Administrator will have thirty (30) days after receipt of such notice (the "**Determination Period**") in which to either rectify such event, determine that an event constituting Good Reason does not exist, or determine that an event constituting Good Reason exists. If the Plan Administrator does not take any of such actions within the Determination Period, the Covered Executive may terminate his employment with the Employer for Good Reason immediately at the end of the Determination Period by giving written notice to the Employer within ninety (90) days after the end of the Determination Period, which termination will be a Qualifying Termination effective on the date that such notice is received by the Employer, provided that such date constitutes the Covered Executive's "separation from service" within the meaning of section 409A of the Code. If the Plan Administrator determines that Good Reason does not exist, then (A) the Covered Executive will not be entitled to rely on or assert such event as constituting Good Reason, and (B) the Covered Executive may file a claim pursuant to Article IV within thirty (30) days after the Covered Executive's receipt or written notice of the Plan Administrator's determination. A termination of employment for Good Reason will be treated as an involuntary termination for purposes of the ESP.

(y) "**Human Resources Committee**" means the Human Resources Committee of the Board, which has the authority to amend and terminate the ESP as provided in Article VI.

(z) "**Key Employee**" means any employee or former employee of the Employer (including any deceased employee) who at any time during the Plan Year was:

(i) an officer of the Company or an Affiliate having compensation of greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code for Plan Years beginning after December 31, 2002) (such limit is one hundred eighty five thousand dollars ($185,000) for 2020);

(ii) a Five Percent Owner; or

(iii) a One Percent Owner having compensation within the meaning of section 415(c) of the Code of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or One Percent Owner in accordance with section 1.415(c)-2(d)(4) of the Treasury Regulations (*i.e.*, W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections) under section 132(f) of the Code (regarding qualified transportation fringe benefits) or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special

timing rules and special rules set forth, respectively, in sections 1.415(c)-2(e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (*i.e.*, the identification date). Employees that are Key Employees during such twelve (12) month period will be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (*i.e.*, since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder. For purposes of determining whether an employee or former employee is an officer, a Five Percent Owner or a One Percent Owner, the Company and each Affiliate will be treated as a separate employer (*i.e.*, the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.1(z)(i), compensation from the Company and all Affiliates will be taken into account (*i.e.*, the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.1(z)(i), no more than fifty (50) employees of the Company or its Affiliates (*i.e.*, the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50), the determination of which employees or former Employees are officers will be determined based on who had the largest annual compensation from the Company and Affiliates for the Plan Year.

(aa) **"One Percent Owner"** means any person who would be described as a Five Percent Owner in Section 2.1(u) if "one percent (1%)" were substituted for "five percent (5%)" each place where it appears therein.

(bb) **"Parent"** means an entity that controls another entity directly, or indirectly through one or more intermediaries, and that itself is not a Subsidiary.

(cc) **"Plan Administrator"** means the individual or committee appointed by the RPAC to handle the day-to-day administration of the ESP. If the RPAC does not appoint an individual or committee to serve as the Plan Administrator, the RPAC will be the Plan Administrator.

(dd) **"Plan Year"** means the fiscal year of the ESP, which will commence on January 1 each year and end on December 31 of such year.

(ee) **"Potential Change of Control"** means the earliest to occur of:

(i) the Company enters into an agreement the consummation of which, or the approval by the stockholders of which, would constitute a Change of Control;

(ii) proxies for the election of members of the Board are solicited by any person other than the Company;

(iii) any person publicly announces an intention to take or to consider taking actions which, if consummated would constitute a Change of Control; or

(iv) any other event occurs which is deemed to be a potential change of control by the Board and the Board adopts a resolution to the effect that a Potential Change of Control has occurred.

(ff) "**Protection Period**" means the period beginning on the date that is six (6) months before the occurrence of a Change of Control and ending twenty-four (24) months after the occurrence of a Change of Control.

(gg) "**Qualifying Termination**" means the Covered Executive's "separation from service" (within the **meaning** of section 409A of the Code) by reason of:

(i) the involuntary termination of a Covered Executive's employment by the Employer without Cause, or

(ii) the Covered Executive's resignation from the employment of the Employer for Good Reason;

provided, however, that a Qualifying Termination will not occur by reason of the divestiture of an Affiliate with respect to a Covered Executive employed by such Affiliate who is offered a comparable position with the purchaser and either declines or accepts such position as provided in Section 6.4.

(hh) "**Reimbursement Period**" means the period of time commencing as of the date of the Covered Executive's Qualifying Termination and ending as of the close of the second taxable year of the Covered Executive that follows the taxable year in which such Qualifying Termination occurred.

(ii) "**RPAC**" means the **Retirement** Plans Administration Committee of the Company established by the Human Resources Committee and whose members have been appointed by the Human Resources Committee or a delegate thereof. The RPAC will have the responsibility to administer the ESP and make final determinations regarding claims for benefits, as described in Article IV.

(jj) "**SERP**" means the Tenet Healthcare Corporation Supplemental Executive Retirement Plan or any other **supplemental** executive retirement plan maintained by the Employer in which Covered Executives participate.

(kk) "**Severance Pay**" means, **except** as provided otherwise in the Covered Executive's ESP Agreement, as follows:

(i) **Pre-Fourth Amended and Restated ESP Covered Executives**. For Covered Executives who entered into an ESP Agreement prior to the execution date for the Tenet Fourth Amended and Restated Executive

Severance Plan, the sum of the Covered Executive's Base Salary and Target Bonus as of the date of a Qualifying Termination, and

(ii) **Fourth Amended and Restated ESP Covered Executives**. For Covered Executives who entered into an ESP Agreement on or after the execution date for the Tenet Fourth Amended and Restated Executive Severance Plan and are not described in Section 2.1(kk)(iii) below, the sum of the Covered Executive's Base Salary and Average Bonus as of the date of a Qualifying Termination.

(iii) **Covered Executives Hired or Promoted On or After Effective Date**. For Covered Executives who on and after the Effective Date are first employed or promoted into a Tier I or Tier II Covered Position (i.e., who were not participants before such employment or promotion), the following amounts:

(A) With respect to Severance Pay payable on account of a Qualifying Termination outside of a Protection Period, the amount set forth below:

Employment Period	Tier I	Tier II
Employed by an Employer for Less than Six (6) Months	The Covered Executive's Base Salary as of the date of the Qualifying Termination	The Covered Executive's Base Salary as of the date of the Qualifying Termination
Employed by an Employer for at Least Six (6) Months but Less than One (1) Year	The sum of the Covered Executive's Base Salary and prorated prior year actual Bonus, if any, (calculated as a fraction of twelve (12) for full months worked by the Covered Executive) as of the date of the Qualifying Termination	The sum of the Covered Executive's Base Salary and prorated prior year actual Bonus, if any, (calculated as a fraction of twelve (12) for full months worked by the Covered Executive) as of the date of the Qualifying Termination
Employed by an Employer for One (1) Year or More	The sum of the Covered Executive's Base Salary and prior year actual Bonus, if any, as of the date of the Qualifying Termination	The sum of the Covered Executive's Base Salary and prior year actual Bonus, if any, as of the date of the Qualifying Termination

(B) With respect to Severance Pay payable on account of a Qualifying Termination during a Protection Period, the amount set forth below:

Employment Period	Tier I	Tier II
Employed by an Employer for Less than Six (6) Months	The Covered Executive's Base Salary as of the date of the Qualifying Termination	The Covered Executive's Base Salary as of the date of the Qualifying Termination
Employed by an Employer for at Least Six (6) Months but Less than One (1) Year	The sum of the Covered Executive's Base Salary and prorated prior year actual Bonus, if any, (calculated as a fraction of twelve (12) for full months worked by the Covered Executive) as of the date of the Qualifying Termination	The sum of the Covered Executive's Base Salary and prorated prior year actual Bonus, if any, (calculated as a fraction of twelve (12) for full months worked by the Covered Executive) as of the date of the Qualifying Termination
Employed by an Employer for One (1) Year or More	The sum of the Covered Executive's Base Salary and prior year actual Bonus, if any, as of the date of the Qualifying Termination	The sum of the Covered Executive's Base Salary and prior year actual Bonus, if any, as of the date of the Qualifying Termination

(II) "**Severance Period**" means

(i) **Pre-November 6, 2013 Covered Executives.** For a Covered Executive who entered into an ESP Agreement before the execution date of the Tenet Third Amended and Restated Executive Severance Plan and except as provided otherwise in the Covered Executive's ESP Agreement or offer letter:

(A) the period specified in Section 3.1(a) of the Tenet Second Amended and Restated Executive Severance Plan with respect to Severance Pay payable on account of a Qualifying Termination not related to a Change of Control as set forth below, and

Covered Executive	Severance Period
Tenet CEO	Three (3) years
COO and CFO	Two and one-half (2.5) years
SVPs and EVPs	One and one-half (1.5) years
VPs and Hospital CEOs	One (1) year

(B) the period specified in Section 3.2(a) of the Tenet Second Amended and Restated Executive Severance Plan on account of

a Qualifying Termination in connection with a Change of Control as set forth below:

Covered Executive	Severance Period
Tenet CEO	Three (3) years
COO and CFO	Three (3) years
SVPs and EVPs	Two (2) years
VPs and Hospital CEOs	One and one-half (1.5) years

(ii) **Post-November 6, 2013 and Vanguard Covered Executives.** For a Covered Executive who entered into an ESP Agreement on and after the execution date for the Tenet Third Amended and Restated Executive Severance Plan, and for a Covered Executive employed by Vanguard Health System Inc. or its Controlled Group Members regardless of when first employed, in each case, to the extent not covered by Section 2.1(ll)(iii) below, the periods specified in the Covered Executive's ESP Agreement or if no such periods are specified the periods specified in Section 2.1(ll)(i)(A) and Section 2.1(ll)(i)(B) above, as applicable, based on the position of the Covered Executive as determined by the Plan Administrator or Executive Vice President, Human Resources. As required by section 409A of the Code, any Severance Period specified in the Covered Executive's ESP Agreement will be the same for a Qualifying Termination occurring outside of the Protection Period and a Qualifying Termination occurring during that portion of the Protection Period that precedes a Change of Control described in Section 2.1(h)(iv). A different Severance Period may apply for a Qualifying Termination that occurs at any time during the Protection Period with respect a Change of Control described in Section 2.1(h)(i), Section 2.1(h)(ii) or Section 2.1(h)(iii) or during that portion of the Protection Period that occurs on or after a Change of Control described in Section 2.1(h)(iv).

(iii) **Post-Effective Date New Hires and Promotions**. For a Covered Executive who is first employed or promoted to a Tier I or Tier II Covered Position on and after the Effective Date, unless specified otherwise in the Covered Executive's ESP Agreement, the periods specified below:

(A) With respect to a Qualifying Termination outside of a Protection Period, the "Severance Period" will be as set forth in the table below:

Covered Executive	Employed by an Employer for Less than Six (6) Months	Employed by an Employer for at least Six (6) Months But Less than one (1) Year	Employed by an Employer for One (1) Year or more
Tier I	Twenty-Six (26) weeks	Period of Whole Months of Employment	One (1) year
Tier II	Twelve (12) weeks	Period of Whole Months of Employment, up to a maximum of nine (9) months	Nine (9) months

(B) With respect to a Qualifying Termination that occurs during the Protection Period with respect to a Change of Control, the “Severance Period” will be as set forth in the table below:

Covered Executive	Employed by an Employer for Less than Six Months	Employed by an Employer for at least Six (6) Months But Less than one (1) Year	Employed by an Employer for One (1) Year or more
Tier I	One (1) year	Period of Whole Months of Employment plus six (6) months	Eighteen (18) months
Tier II	Nine (9) months	Period of Whole Months of Employment plus six (6) months	Fifteen (15) months

(mm) "**SIP**" means the Third Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan, the Tenet Healthcare 2008 Stock Incentive Plan, the Tenet Healthcare 2019 Stock Incentive Plan, or any successor to such plans.

(nn) "**Subsidiary**" means an entity controlled by another entity directly, or indirectly through one or more intermediaries.

(oo) "**Target Bonus**" means the target bonus percent applicable to the Covered Executive under the AIP multiplied by his Base Salary at the time of a Qualifying Termination. For example, if the Covered Executive earns one hundred and fifty

thousand dollars ($150,000) and has a target bonus percent of fifty percent (50%), his Target Bonus equals seventy-five thousand dollars ($75,000).

(pp) "**TESPP**" means the ESP in effect immediately before May 11, 2006.

(qq) "**Tier I**" means the benefits payable to a Covered Executive who was first hired or promoted on or after the Effective Date who is designated as a Tier I Covered Executive.

(rr) "**Tier II**" means the benefits payable to a Covered Executive who was first hired or promoted on or after the Effective Date who is designated as a Tier II Covered Executive.

.2 **Construction.** If any provision of the ESP is determined to be for any reason invalid or unenforceable, the remaining provisions of the ESP will continue in full force and effect. All of the provisions of the ESP will be construed and enforced in accordance with the laws of the State of Texas and will be administered according to the laws of such state, except as otherwise required by ERISA, the Code or other applicable federal law. When delivery to the RPAC, Plan Administrator or the Covered Executive is required under this ESP, such delivery requirement will be satisfied by delivery to a person or persons designated by the RPAC, Plan Administrator or delivery to the Covered Executive, as applicable. Delivery will be deemed to have occurred only when the form or other communication is actually received. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of the ESP. The pronouns "he," "him" and "his" used in the ESP will also refer to similar pronouns of the female gender unless otherwise qualified by the context.

.3 **409A Compliance.** The ESP is intended to either be exempt from or comply with the requirements of section 409A of the Code. The provisions of the ESP will be construed and administered in a manner that enables the ESP to comply with the provisions of section 409A of the Code.

End of Article II

ARTICLE III
SEVERANCE BENEFITS

3.1 Severance Benefits Not Related to a Change of Control. Except as provided otherwise in a Covered Executive's ESP Agreement, a Covered Executive who incurs a Qualifying Termination outside of the Protection Period, subject to the limitations contained in the ESP, will receive the following severance benefits.

(a) **Severance Period**. The Covered Executive will be entitled to the payment of Severance Pay over the Severance Period as specified in Section 2.1(ll)(i)(A), 2.1(ll)(ii) or Section 2.1(ll)(iii)(A), as applicable.

Such Severance Pay will be paid on a bi-weekly basis commencing as of the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period, subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (i.e., the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed). All distributions from the ESP will be taxable as ordinary income when received and subject to appropriate withholding of income taxes and reported on Form W-2. Except as otherwise provided herein, a Covered Executive who incurs a Qualifying Termination will have formally terminated his employment relationship with the Employer as of the date of such Qualifying Termination and will not be deemed to be an Employee at any time during the Severance Period or thereafter.

(b) **Other Accrued Obligations**. The Covered Executive will be entitled to payment of all accrued Base Salary, accrued time off and any other accrued and unpaid obligations as of the date of the Qualifying Termination. Such accrued obligations will be included and paid as part of the Covered Executive's final paycheck from the Employer or otherwise paid in accordance with the requirements of applicable law.

(c) **Bonus**. The Covered Executive will be entitled to payment of the Bonus earned in accordance with the terms of the AIP for performance during and as acted on by the Human Resources Committee during the calendar year of the Qualifying Termination. Such Bonus will be prorated as a fraction of twelve (12) for months worked (including full credit for a partial month worked) by the Covered Executive for the Employer or an Affiliate during such calendar year and will be paid to the Covered Executive, at the time and in the manner otherwise specified in the AIP.

(d) **Continued Welfare Benefits**. During the Severance Period, the Covered Executive and his dependents will be entitled to continue to participate in any medical, dental, vision, life and long-term care benefit programs maintained by the Employer in which such persons were participating immediately before the date of the Qualifying Termination; provided, that the continued participation of such persons is possible under the general terms and provisions of such benefit programs. If such continued participation is barred, then the Employer will arrange to provide such persons with substantially similar coverage or

reimbursement for the cost of substantially similar coverage to that which such persons would have otherwise been entitled to receive under such benefit programs from which such continued participation is barred. In either case, however, the Covered Executive will be required to continue to pay, on a pre-tax or after-tax basis, as applicable, his portion of the cost of such coverages as in effect at the time of the Qualifying Termination, and the Employer will continue to pay (or to reimburse the Covered Executive for) its portion of such costs, as in effect at the time of the Qualifying Termination. Any coverage provided pursuant to this Section 3.1(d) will be limited and reduced to the extent equivalent coverage is otherwise provided by (or available from or under) any other employer of the Covered Executive. The Covered Executive must advise the Plan Administrator of the attainment or availability of any such subsequent employer benefit coverages within thirty (30) days following such attainment.

The pre-tax or after-tax payroll deductions for the continued medical, dental, vision life and long-term care benefits described above will be taken from the Covered Executive's Severance Pay pursuant to the Employer's normal payroll practices; provided, however, that if any of such coverages are provided on a self-insured basis, the Covered Executive will be required to pay his portion of the cost of such coverages on an after-tax basis and the remainder of such cost will be included in the Covered Executive's income and reported as wages on Form W-2. Any continued medical, dental or vision benefits provided to the Covered Executive and his dependents pursuant to this Section 3.1(d) is in addition to any rights the Covered Executive and such dependents may have to continue such coverages under COBRA. The provisions of this Section 3.1(d) will not prohibit the Company from changing the terms of such medical, dental, life vision or long-term care benefit programs provided that any such changes apply to all executives of the Company and its Affiliates (e.g., the Company may switch insurance carriers or preferred provider organizations).

(e) **Outplacement Services**. Except with respect to Tier I or Tier II Covered Executives who will not be entitled to any outplacement services, the Covered Executive will be entitled to reimbursement of any expenses reasonably incurred by him for outplacement services in an amount equal to the lesser of ten percent (10%) of his Base Salary or twenty-five thousand dollars ($25,000). In order to comply with the exemption applicable to post-separation reimbursement plans under section 409A of the Code: (i) the reimbursement of such expenses for outplacement services only will be permitted with respect to expenses that are incurred during the shorter of the Severance Period or the Reimbursement Period and (ii) any reimbursement of such expenses that are incurred during a particular taxable year of the Covered Executive must be made by the last day of the Covered Executive’s immediately following taxable year.

(f) **Payment of Legal Expenses**. The Covered Executive will be entitled to reimbursement of any legal expenses reasonably incurred by him in order to obtain benefits under the ESP; provided, that, the payment of such expenses is subject to an arms-length, bona fide dispute as to the Covered Executive's right to such benefits. In order to comply with the exemption applicable to post-separation reimbursement plans under section 409A of the Code, in the event

such legal expenses are otherwise deductible under section 162 or 167 of the Code (without regard to any limitation on the Covered Executive's adjusted gross income): (i) the reimbursement of such legal expenses only will be permitted with respect to expenses that are incurred during the shorter of the Severance Period or the Reimbursement Period; and (ii) any reimbursement of such legal expenses that are incurred during a particular taxable year of the Covered Executive must be made by the last day of the Covered Executive's immediately following taxable year. In the event that the legal expenses are not otherwise deductible under section 162 or 167 or the Code (without regard to any limitation on the Covered Executive's adjusted gross income), then in order to comply with the expense reimbursement provisions of section 409A of the Code, the reimbursement of such expenses will be made pursuant to the terms of Section 3.1(f)(i) and Section 3.1(f)(ii) above; provided, that the amount of legal expenses reimbursed or eligible for reimbursement during a taxable year of the Covered Executive that occurs during the Severance Period or Reimbursement Period will not affect the legal expenses that are eligible for reimbursement in any other taxable year of the Covered Executive that occurs during the Severance Period or Reimbursement Period and that such legal expense reimbursement amounts will be subject to the six (6) month delay (when applicable) for distributions in excess of the 409A Exempt Amount as set forth in Section 3.3.

(g) **Equity Compensation Adjustments**. Except as provided otherwise in the Covered Executive's ESP Agreement, upon a Qualifying Termination, any equity-based compensation awards granted to the Covered Executive by the Employer under the SIP or an Equity Plan before such termination that are outstanding and vested as of the date of the Qualifying Termination will be exercisable or settled pursuant to the terms of the SIP or the Equity Plan, as applicable. All unvested equity-based compensation awards held by the Covered Executive as of the date of the Qualifying Termination will expire and be of no effect, except to the extent that the terms of such awards provide for continued vesting and/or acceleration. No Covered Executive will be entitled to any new equity-based compensation awards following the date of his Qualifying Termination or during the Severance Period.

(h) **SERP**. A Covered Executive who is also a participant in the SERP and became such a participant before August 3, 2011 will be entitled to age and service credit for the duration of the Severance Period under the SERP. A Covered Executive who is also a participant in the SERP but became such a participant on or after August 3, 2011 will not be entitled to age and service credit for the duration of the Severance Period under the SERP. Benefits under the SERP will be payable to the Covered Executive pursuant to the terms of the SERP; provided, however, that if the Covered Executive is entitled to commence SERP benefits during the Severance Period pursuant to the terms of the SERP; the amount of Severance Pay payable to Executive pursuant to the ESP will be offset (i.e., reduced) by the amount of the SERP benefits payable during the Severance Period. With respect to a Covered Executive who became a SERP participant before August 3, 2011, for purposes of determining the amount of the Covered Executive's SERP benefits, any actuarial reduction that would otherwise apply under the SERP due to the commencement of SERP benefits during the Severance Period will be

disregarded (i.e., the SERP benefits will only be actuarially reduced for early commencement beginning with the last day of the Severance Period). Further, while the age credit will accrue throughout the course of the Severance Period, at the end of the Severance Period, the Covered Executive's SERP benefits will be recalculated to take into account the additional service credit provided under the ESP during the Severance Period. With respect to a Covered Executive who became a SERP participant on or after August 3, 2011, for purposes of determining the amount of the Covered Executive's SERP benefits, the actuarial reduction will be determined under the terms of the SERP as of the date of the Covered Executive's Qualifying Termination. A Covered Executive's Severance Pay will not be considered in calculating the Covered Executive's "Final Average Earnings" under the SERP. Notwithstanding the foregoing, in no event will any provision in this Section 3.1(h) be construed to permit the distribution of any SERP benefits during the six (6) month restriction period, as described in the SERP, which follows a Key Employee's Qualifying Termination.

(i) **DCP**. The Covered Executive will incur a termination of employment for purposes of the DCP at the time of a Qualifying Termination and accordingly will not be entitled to defer any portion of his Severance Pay to the DCP during the Severance Period. The Covered Executive's DCP benefits will be paid to him pursuant to the terms of the DCP and the Covered Executive's distribution election under the DCP in a manner that complies with section 409A of the Code.

(j) **401(k)**. The Covered Executive will incur a severance from employment for purposes of the 401(k) Plan on the date of the Qualifying Termination and accordingly will not be entitled to defer any portion of his Severance Pay to the 401(k) Plan during the Severance Period. The Covered Executive's 401(k) Plan benefits will be payable to him under the 401(k) Plan pursuant to the terms of the 401(k) Plan.

3.2 Severance Benefits Related to a Change of Control. Except as provided otherwise in a Covered Executive's ESP Agreement, a Covered Executive who incurs a Qualifying Termination during the Protection Period with respect to a Change of Control will, subject to the limitations contained in the ESP, receive the severance benefits described in Section 3.1, (provided, however, that a Covered Executive will only receive the additional age and service credit as set forth in Section 3.1(h) herein in accordance with the terms and provisions of the SERP), plus the additional severance benefits, if any, provided in this Section 3.2. Further, within five (5) business days following the occurrence of a Change of Control, the Company must contribute to a domestic rabbi trust an amount sufficient to fully fund the severance benefits accrued as of the date of the Change of Control pursuant to this Section 3.2. Such funding obligation will continue for each calendar quarter during the twenty-four (24) month period following such Change of Control, with such funding to be made within five (5) business days following the end of each such calendar quarter.

(a) **Severance Period**. The Covered Executive will be entitled to the payment of Severance Pay for the Severance Period as specified in Section 2.1(ll)(i)(B), 2.1(ll)(ii) or Section 2.1(ll)(iii)(B), as applicable.

(b) **Payment of Severance Pay**. In the event that a Covered Executive's Qualifying Termination occurs during the portion of the Protection Period that precedes any Change of Control described in Section 2.1(h)(i), Section 2.1(h)(ii) or Section 2.1(h)(iii), the Covered Executive will receive Severance Pay that will be paid on a bi-weekly basis commencing on the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (*i.e.*, the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed). To the extent that such Change of Control is described in Section 2.1(h)(iv), such Severance Pay in excess of the 409A Exempt Amount will be paid on a bi-weekly basis commencing on the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period specified in Section 3.1(a) subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (*i.e.*, the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed).

In the event that a Covered Executive's Qualifying Termination occurs during the portion of the Protection Period that occurs on or after a Change of Control described in Section 2.1(h)(i), Section 2.1(h)(ii) or Section 2.1(h)(iii), the Covered Executive will receive, subject to the six (6) month delay for distributions in excess of the 409A Exempt Amount as set forth in Section 3.3, a lump sum payment of Severance Pay, in the amount determined pursuant to Section 3.2(a), within ninety (90) days following such Qualifying Termination. To the extent that such Change of Control is described in Section 2.1(h)(iv), such Severance Pay in excess of the 409A Exempt Amount will be paid on a bi-weekly basis commencing on the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (*i.e.*, the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed).

The payment provisions of this Section 3.2(b) are summarized below.

Change of Control Event	Qualifying Termination During Protection Period Occurring Before Change of Control	Qualifying Termination During Protection Period Occurring on and After a Change Of Control
Section 2.1(h)(i) - change in stock ownership	● Bi-weekly payment of Severance Pay over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay (if any) paid in Lump sum subject to six (6) month delay
Section 2.1(h)(ii) - change in effective control	● Bi-weekly payment of Severance over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay (if any) paid in Lump sum subject to six (6) month delay
Section 2.1(h)(iii) - sale of assets	● Bi-weekly payment of Severance Pay over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay paid in Lump sum subject to six (6) month delay
Section 2.1(h)(iv) - liquidation or dissolution	● Bi-weekly payment of Severance Pay over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay paid bi-weekly over Severance Period subject to six (6) month delay

(c) **Equity Compensation** Adjustments.

(i) Except as provided otherwise in the Covered Executive's ESP Agreement, in the event of a Change of Control, if the successor to the Company does not assume the SIP or the applicable Equity Plan or grant comparable awards in substitution of the outstanding awards under the SIP or applicable Equity Plan as of the date of the Change of Control, then any equity-based compensation awards granted to the Covered Executive by the Employer under the SIP or Equity Plan and outstanding as of the date of the Change of Control will become immediately fully vested and/or exercisable and will no longer be subject to a substantial risk of forfeiture or restrictions on transferability, other than those imposed by applicable legislative or regulatory requirements. With respect to performance cash awards, however, in the event the successor to the Company does not assume the awards, the awards will become payable at earned levels for completed plan years and at target performance levels for the year in which the Change of Control occurs and future plan years, as applicable, payable in accordance with the terms of such

awards, and if not addressed in an award agreement, then payable on the date of the Change of Control.

(ii) Except as provided otherwise in the Covered Executive's ESP Agreement, if the successor to the Company assumes the SIP or the applicable Equity Plan or substitutes the awards under the SIP or applicable Equity Plan with comparable awards, then any equity-based compensation awards granted to the Covered Executive by the Employer under the SIP or Equity Plan before such termination and outstanding as of the date of the Change of Control or any substituted awards given with respect to such outstanding awards will continue to be maintained pursuant to their terms; provided, however, that upon a Covered Executive's Qualifying Termination during the Protection Period in connection with such Change of Control, any such equity compensation awards outstanding as of the date of the Qualifying Termination will become immediately vested and/or exercisable, in accordance with the terms of such awards, except as set forth below in this paragraph, on the date of the Qualifying Termination or, if the Qualifying Termination occurs during the portion of the Protection Period that precedes the Change of Control, then on the date of the Change of Control, and will no longer be subject to a substantial risk of forfeiture or restrictions on transferability, other than those imposed by applicable legislative or regulatory requirements. With respect to performance cash awards, however, upon a Qualifying Termination during the Protection Period in connection with such Change of Control, a Covered Executive will be paid earned amounts for completed plan years and target amounts for the year in which the Qualifying Termination occurs and future plan years, as applicable, payable on the scheduled payment date. Furthermore, with respect to performance-based restricted stock units and performance options, upon a Qualifying Termination during the Protection Period in connection with such Change of Control, accelerated vesting is only provided to the extent that the applicable performance criteria are achieved (with pro rata vesting based on service during the performance period if the termination occurs during the performance period). No Covered Executive will be entitled to any new equity-based compensation awards following the date of his Qualifying Termination or during the Severance Period.

(d) **Parachute Limitation**.

(i) If at any time or from time to time, it is determined by an independent nationally known financial accounting or law firm experienced in such matters selected by the Company ("**Tax Professional**") that any payment or other benefit to the Covered Executive pursuant to the ESP or otherwise ("**Potential Parachute Payment**") is or will, but for the provisions of this Section 3.2(d), become subject to the excise tax imposed by section 4999 of the Code or any similar tax payable under any state, local, foreign or other law, but expressly excluding any income taxes and penalties or interest imposed pursuant to section 409A of the

Code ("**Excise Taxes**"), then the Covered Executive's Potential Parachute Payment will be either (A) provided to the Covered Executive in full, or (B) provided to the Covered Executive as to such lesser extent which would result in no portion of such benefits being subject to the Excise Taxes, whichever of the foregoing amounts, when taking into account applicable federal, state, local and foreign income and employment taxes, the Excise Tax, and any other applicable taxes, results in the receipt by the Covered Executive, on an after-tax basis, of the greatest amount of benefits, notwithstanding that all or some portion of such benefits may be taxable under the Excise Taxes ("**Payments**").

(ii) In the event of a reduction of benefits pursuant to Section 3.2(d)(i), the Tax Professional will determine which benefits will be reduced so as to achieve the principle set forth in Section 3.2(d)(i). For purposes of making the calculations required by Section 3.2(d)(i), the Tax Professional may make reasonable assumptions and approximations concerning applicable taxes and may rely on reasonable, good faith interpretations concerning the application of the Code and other applicable legal authority. The Company and the Covered Executive will furnish to the Tax Professional such information and documents as the Tax Professional may reasonably request in order to make a determination under Section 3.2(d)(i). The Company will bear all costs the Tax Professional may reasonably incur in connection with any calculations contemplated by Section 3.2(d)(i).

(iii) If, notwithstanding any calculations performed or reduction in benefits imposed as described in Section 3.2(d)(i), the IRS determines that the Covered Executive is liable for Excise Taxes as a result of the receipt of any payments made pursuant to this ESP or otherwise, then the Covered Executive will be obligated to pay back to the Company, within thirty (30) days after a final IRS determination or in the event that the Covered Executive challenges the final IRS determination, a final judicial determination, a portion of the Payments equal to the "Repayment Amount." The Repayment Amount will be the smallest such amount, if any, as will be required to be paid to the Company so that the Covered Executive's net after-tax proceeds with respect to the Payments (after taking into account the payment of the Excise Taxes and all other applicable taxes imposed on such benefits) are maximized. The Repayment Amount will be zero if a Repayment Amount of more than zero would not result in the Covered Executive's net after-tax proceeds with respect to the Payments being maximized. If the Excise Taxes are not eliminated pursuant to this Section 3.2(d)(iii), the Covered Executive will pay the Excise Taxes.

(iv) Notwithstanding any other provision of this Section 3.2(d), if (A) there is a reduction in the payments to a Covered Executive as described above in this Section 3.2(d), (B) the IRS later determines that the Covered Executive is liable for Excise Taxes, the payment of which would result in the maximization of the Covered Executive's net after-tax proceeds

(calculated based on the full amount of the Potential Parachute Payment and as if the Covered Executive's benefits had not previously been reduced), and (C) the Covered Executive pays the Excise Tax, then the Company will pay to the Covered Executive those payments which were reduced pursuant to Section 3.2(d)(i) or 3.2(d)(iii) as soon as administratively possible after the Covered Executive pays the Excise Taxes to the extent that the Covered Executive's net after-tax proceeds with respect to the payment of the Payments are maximized.

3.3 Termination Distributions to Key Employees. A portion of the distributions under the ESP that are payable to a Covered Executive who is a Key Employee on account of a Qualifying Termination will be delayed for a period of six (6) months following such Covered Executive's Qualifying Termination to the extent such distributions under the ESP exceed the 409A Exempt Amount. Upon the expiration of such six (6) month period, amounts that would have been paid to the Covered Executive during such six (6) month period, will be paid to him on the first business day following the close of such period in the form of a lump sum payment and the remaining amounts payable to the Covered Executive under the ESP will be paid with respect to the remainder of the Severance Period pursuant to the terms of this Article III (*e.g.*, Severance Pay will be paid on a bi-weekly basis for the remainder of the Severance Period in the case of (i) Severance Pay that is not payable on account of a Change in Control, (ii) Severance Pay that is payable on account of a Qualifying Termination during the portion of the Protection Period that precedes a Change in Control described in Section 2(h)(i), 2(h)(ii) or 2(h)(iii), and (iii) Severance Pay that is payable on account of a Qualifying Termination during the portion of the Protection Period that occurs on and after a Change of Control described in Section 2.1(h)(iv)). This six (6) month restriction will not apply, or will cease to apply, with respect to distributions by reason of the death of the Covered Executive pursuant to Section 3.4.

3.4 Distributions on Account of Death of the Covered Executive During the Severance Period. Except as provided otherwise in the Covered Executive's ESP Agreement, if a Covered Executive dies during the Severance Period the following benefits will be payable:

(a) **Severance Pay**. Any remaining Severance Pay payable to the Covered Executive as of the date of his death will continue to be paid to the Covered Executive's estate pursuant to Section 3.1(a) or 3.2(a), as applicable.

(b) **Other Accrued Obligations**. Any unpaid Base Salary, time off and any other accrued and unpaid obligations that remain outstanding as of the date of the Covered Executive's death will be paid to the Covered Executive's estate pursuant to Section 3.1(b).

(c) **Bonus**. Any unpaid Bonus described under Section 3.1(c) that remains outstanding as of the date of the Covered Executive's death will be paid to the Covered Executive's estate pursuant to Section 3.1(c).

(d) **Continued Welfare Benefits**. The Covered Executive's dependents will be entitled to continue to participate in any medical, dental, vision, life and long-term care benefit programs maintained by the Employer in which such persons were participating immediately before the date of the Covered Executive's death for

the remainder of the Severance Period, subject to the provisions of Section 3.1(d). At the end of the Severance Period such dependents will be eligible to elect to continue their medical, dental or vision coverage pursuant to COBRA.

(e) **Outplacement Services**. Any outplacement service benefits payable to the Covered Executive pursuant to Section 3.1(e) will cease as of the date of the Covered Executive's death; provided, that any eligible outplacement expenses incurred before the Covered Executive's death will be reimbursable to the Covered Executive's estate pursuant to Section 3.1(e).

(f) **Payment of Legal Expenses**. The obligation to reimburse the Covered Executive for any legal fees will continue pursuant to the terms of the ESP following his death, except that such legal fees will be payable to the Covered Executive's estate.

(g) **Equity Compensation Adjustments**. Any outstanding equity-based compensation awards granted to the Covered Executive that are outstanding as of the date of the Covered Executive's death will be exercisable or settled pursuant to the terms of the SIP or the Equity Plan, as applicable.

3.5 Section 409A Gross-Up Payment. In the event that a Covered Executive (or his estate) pays the excise taxes and any other interest and penalty payments (as applicable) pursuant to section 409A of the Code ("**409A Excise Tax**") with respect to the benefits payable under the ESP, the Covered Executive (or his estate) will be entitled to a reimbursement equal to the amount of any 409A Excise Tax paid by the Covered Executive (or his estate) pursuant to section 409A of the Code. The Company will provide a reimbursement to the Covered Executive with respect to any payment of the 409A Excise Tax (or portion thereof) no later than the close of the Covered Executive's taxable year that immediately follows the taxable year in which such payment is made. If the Covered Executive is a Key Employee, payment of the amounts described in this Section 3.5 will be subject to a six (6) month delay (when applicable) for distributions in excess of the 409A Exempt Amount as provided in Section 3.3. This Section 3.5 will not apply to Covered Executives hired or promoted into a Tier I or Tier II Covered Position on or after the Effective Date.

3.6 Alternate Plan Terms. Subject to the requirements of section 409A of the Code, the Executive Vice President, Human Resources and/or Plan Administrator reserves the right to modify the terms of this ESP with respect to any Covered Executive (*e.g.*, to provide different benefits than those set forth herein). Such modified terms will be set forth in the Covered Executive's ESP Agreement or in such other form as may be determined by the Executive Vice President, Human Resources and/or Plan Administrator, each in its sole and absolute discretion.

3.7 Conditions to Payment of Severance Benefits. As a condition of obtaining benefits under the ESP, the Covered Executive will be required to execute a Severance Agreement and General Release. Such Severance Agreement and General Release will contain the restrictive covenants set forth below regarding non-competition, confidentiality, non-disparagement and non-solicitation as well as a general release of claims against the Company and its Affiliates.

(a) **Non-Competition**. Payment of any and all severance benefits provided under the ESP will cease if, at any time during the Severance Period described in

Section 3.1(a), the Covered Executive directly or indirectly, carries on or conducts, in competition with the Company and its Affiliates, any business of the nature in which the Company or its Affiliates are then engaged in any geographical area in which the Company or its Affiliates engage in business at the time of the Covered Executive's Qualifying Termination or in which any of them, before such Qualifying Termination, evidenced in writing, at any time during the six (6) month period before such termination, an intention to engage in such business. This prohibition extends to the Covered Executive's conducting or engaging in any such business either as an individual on his own account or as a partner or joint venturer or as an executive, agent, consultant or salesman for any other person or entity, or as an officer or director of a corporation or as a shareholder in a corporation of which he will then own ten percent (10%) or more of any class of stock. The provisions of this Section 3.7(a) will not apply with respect to severance benefits payable pursuant to Section 3.2(a).

(b) **Confidential Information**. Payment of any and all severance benefits will cease if, at any time, the Covered Executive directly or indirectly reveals, divulges or makes known to any person or entity, or uses for the Covered Executive's personal benefit (including without limitation for the purpose of soliciting business, whether or not competitive with any business of the Company or any of its Affiliates), any information acquired during the Covered Executive's employment with the Company or its Affiliates with regard to the financial, business or other affairs of the Company or any of its Affiliates (including without limitation any list or record of persons or entities with which the Company or any of its Affiliates has any dealings), other than:

(i) information already in the public domain,

(ii) information of a type not considered confidential by persons engaged in the same business or a business similar to that conducted by the Company or its Affiliates, or

(iii) information that the Covered Executive is required to disclose under the following circumstances:

(A) at the express direction of any authorized governmental entity;

(B) pursuant to a subpoena or other court process;

(C) as otherwise required by law or the rules, regulations, or orders of any applicable regulatory body; or

(D) as otherwise necessary, in the opinion of counsel for the Covered Executive, to be disclosed by the Covered Executive in connection with any legal action or proceeding involving the Covered Executive and the Company or any Affiliate in his capacity as an employee, officer, director, or stockholder of the Company or any Affiliate.

The Covered Executive will, at any time requested by the Company (either during his employment with the Company and its Affiliates or during the Severance Period), promptly deliver to the Company all memoranda, notes, reports, lists and other documents (and all copies thereof) relating to the business of the Company or any of its Affiliates which he may then possess or have under his control.

Pursuant to 18 U.S.C. § 1833(b), no Covered Executive will be held criminally or civilly liable under any Federal or State trade secret law for the disclosure of a trade secret of the Company or any of its Affiliates that—(i) is made—(A) in confidence to a Federal, State, or local government official, either directly or indirectly, or to the Covered Executive's attorney and (B) solely for the purpose of reporting or investigating a suspected violation of law; or (ii) is made in a complaint or other document that is filed under seal in a lawsuit or other proceeding. Nothing in this Agreement is intended to conflict with 18 U.S.C. § 1833(b) or create liability for disclosures of trade secrets that are expressly allowed by such section.

(c) **Agreement Not To Solicit Employees**. Payment of any and all severance benefits will cease if, at any time during the Severance Period the Covered Executive directly or indirectly solicits or induces, or in any manner attempts to solicit or induce, any person employed by, or any agent of, the Company or any of its Affiliates to terminate such employee's employment or agency, as the case may be, with the Company or any Affiliate.

(d) **Nondisparagement**. Payment of any and all severance benefits will cease if, at any time during the Severance Period the Covered Executive disparages the Company or its Affiliates and their respective boards of directors or other governing body, executives, employees and products or services. The Company will instruct its directors and officers to not disparage the Covered Executive during the Covered Executive's period of employment with the Company and its Affiliates or thereafter. For purposes of this Section 3.7(d), disparagement does not include:

(i) compliance with legal process or subpoenas to the extent only truthful statements are rendered in such compliance attempt,

(ii) statements in response to an inquiry from a court or regulatory body, or

(iii) statements or comments in rebuttal of media stories or alleged media stories.

(e) **409A Compliance**. If any payment made under the ESP (i) is subject to the execution of an effective release of claims, (ii) "provides for the deferral of compensation" within the meaning of section 409A of the Code and is not otherwise exempt from the application of section 409A of the Code, and (iii) could be made in either one of two consecutive taxable years on account of the requirement of the execution of an effective release of claims, then such payment will be made in the later taxable year.

The violation of this Section 3.7 by Covered Executive will entitle the Company to complete relief from such violation including, but not limited to, injunctive relief and damages as determined by an arbitrator, the cessation of severance benefits and a return of all severance benefits paid to the Covered Executive pursuant to the terms of the ESP. Such relief will apply regardless of whether such violation is discovered after the expiration of the Severance Period. The violation of Section 3.7(d) by the Company will entitle the Covered Executive to complete relief from such violation including, but not limited to, injunctive relief and damages as determined by an arbitrator.

3.8 Impact of Reemployment on Benefits

If a Participant incurs a Qualifying Termination and begins receiving Severance Pay from the ESP and such Participant is reemployed by the Employer or an Affiliate, then such Participant's Severance Pay will continue as scheduled during the period of his reemployment.

End of Article III

ARTICLE IV
ADMINISTRATION

4.1 The RPAC. The overall administration of the ESP will be the responsibility of the RPAC.

4.2 Powers of RPAC. The RPAC will have sole and absolute discretion regarding the exercise of its powers and duties under the ESP. In order to effectuate the purposes of the ESP, the RPAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the ESP;

(c) To construe the ESP and to make equitable adjustments for any mistakes or errors made in the administration of the ESP; and

(d) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the ESP and any trust established to secure the assets of the ESP:

(i) when differences of opinion arise between the Company, an Affiliate, the Plan Administrator, the trustee, a Covered Executive, or any of them, and

(ii) whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the ESP for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the RPAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the ESP.

4.3 Appointment of Plan Administrator. The RPAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the ESP on a daily basis. The RPAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the RPAC.

4.4 Duties of Plan Administrator. The Plan Administrator will have sole and absolute discretion regarding the exercise of its powers and duties under the ESP. The Plan Administrator will have the following powers and duties:

(a) To enter into, on behalf of the Employer, an ESP Agreement with an Employee who is a Covered Executive pursuant to Section 2.1(l);

(b) To direct the administration of the ESP in accordance with the provisions herein set forth;

(c) To adopt rules of procedure and regulations necessary for the administration of the ESP, provided such rules are not in consistent with the terms of the ESP;

(d) To determine all questions with regard to rights of Covered Executives and beneficiaries under the ESP including, but not limited to, questions involving eligibility of an Employee to participate in the ESP and the level of a Covered Executive's benefits;

(e) to make all final determinations and computations concerning the benefits to which the Covered Executive or his estate is entitled under the ESP;

(f) To enforce the terms of the ESP and any rules and regulations adopted by the RPAC;

(g) To review and render decisions respecting a claim for a benefit under the ESP;

(h) To furnish the Employer with information that the Employer may require for tax or other purposes;

(i) To engage the service of counsel (who may, if appropriate, be counsel for the Employer), accountants, actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(j) To prescribe procedures to be followed by Covered Executives in obtaining benefits;

(k) To receive from the Employer and from Covered Executives such information as is necessary for the proper administration of the ESP;

(l) To create and maintain such records and forms as are required for the efficient administration of the ESP;

(m) To make all initial determinations and computations concerning the benefits to which any Covered Executive is entitled under the ESP;

(n) To give the trustee of any trust established to serve as a source of funds under the ESP specific directions in writing with respect to:

(i) making distribution payments, giving the names of the payees, specifying the amounts to be paid and the time or times when payments will be made; and

(ii) making any other payments which the trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator;

(o) To comply with all applicable reporting and disclosure requirements of ERISA;

(p) To comply (or transfer responsibility for compliance to the trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(q) To construe the ESP, in its sole and absolute discretion, and make equitable adjustments for any errors made in the administration of the ESP.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the ESP.

4.5 Indemnification of RPAC and Plan Administrator. To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations, the Employer agrees to hold harmless and indemnify the members of the RPAC and the Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising out of any act or omission relating to or in connection with the ESP other than losses resulting from the RPAC's, or any such person's commission of fraud or willful misconduct.

4.6 Claims for Benefits.

(a) **Initial Claim**. In the event that a Covered Executive or his estate claims (a "**claimant**") to be eligible for benefits, or claims any rights under the ESP or seeks to challenge the validity or terms of the Severance Agreement and General Release described in Section 3.7, such claimant must complete and submit such claim forms and supporting documentation as will be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any claimant who feels unfairly treated as a result of the administration of the ESP must file a written claim, setting forth the basis of the claim, with the Plan Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the claimant may examine the ESP, and any other pertinent documents generally available to Covered Executives that are specifically related to the claim.

A written notice of the disposition of any such claim will be furnished to the claimant within ninety (90) days after the claim is filed with the Plan Administrator. Such notice will refer, if appropriate, to pertinent provisions of the ESP, will set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of the ESP) and, where appropriate, will describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the claimant will also be notified of the ESP's claim review procedure and the time limits applicable to such procedure, including the claimant's right to arbitration following an adverse benefit determination on review as provided below. All benefits provided in the ESP as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review**. Within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant may file with the RPAC

a written request for review of his claim. In connection with the request for review, the claimant will be entitled to be represented by counsel and will be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the claimant does not file a written request for review within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant will be deemed to have accepted the Plan Administrator's written disposition, unless the claimant was physically or mentally incapacitated so as to be unable to request review within the ninety (90) day period.

(c) **Decision on Review**. After receipt by the RPAC of a written application for review of his claim, the RPAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The RPAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address.

A decision on review of the claim will be made by the RPAC at its next meeting following receipt of the written request for review. If no meeting of the RPAC is scheduled within forty-five (45) days of receipt of the written request for review, then the RPAC will hold a special meeting to review such written request for review within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be rendered within ninety (90) days of receipt of the request for review. In any event, if a claim is not determined by the RPAC within ninety (90) days of receipt of written submission for review, it will be deemed to be denied.

The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the benefit determination is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant ESP provisions on which the decision was based. Such decision will also advise the claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the RPAC will be final and conclusive.

4.7 Arbitration. In the event the claims review procedure described in Section 4.6 of the ESP does not result in an outcome thought by the claimant to be in accordance with the ESP document, he may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within sixty (60) days after receiving the RPAC's denial or deemed denial of his request for review and before bringing suit in court. The arbitration will be conducted pursuant to the American Arbitration Association ("**AAA**") Rules on Employee Benefit Claims.

The arbitrator will be mutually selected by the claimant and the RPAC from a list of arbitrators who are experienced in nonqualified deferred compensation plan benefit matters that is provided by the AAA. If the parties are unable to agree on the selection of

an arbitrator within ten (10) days of receiving the list from the AAA, the AAA will appoint an arbitrator. The arbitrator's review will be limited to interpretation of the ESP document in the context of the particular facts involved. The claimant, the RPAC and the Employer agree to accept the award of the arbitrator as binding, and all exercises of power by the arbitrator hereunder will be final, conclusive and binding on all interested parties, unless found by a court of competent jurisdiction, in a final judgment that is no longer subject to review or appeal, to be arbitrary and capricious.

The claimant, RPAC and the Employer agree that the venue for the arbitration will be in Dallas, Texas. The costs of arbitration will be paid by the Employer; the costs of legal representation for the claimant or witness costs for the claimant will be borne by the claimant; provided, that, as part of his award, the arbitrator may require the Employer to reimburse the claimant for all or a portion of such amounts.

The following discovery may be conducted by the parties: interrogatories, demands to produce documents, requests for admissions and oral depositions. The arbitrator will resolve any discovery disputes by such pre hearing conferences as may be needed. The Employer, RPAC and claimant agree that the arbitrator will have the power of subpoena process as provided by law. Disagreements concerning the scope of depositions or document production, its reasonableness and enforcement of discovery requests will be subject to agreement by the Employer and the claimant or will be resolved by the arbitrator.

All discovery requests will be subject to the proprietary rights and rights of privilege and other protections granted by applicable law to the Employer and the claimant and the arbitrator will adopt procedures to protect such rights. With respect to any dispute, the Employer, RPAC and the claimant agree that all discovery activities will be expressly limited to matters directly relevant to the dispute and the arbitrator will be required to fully enforce this requirement.

The arbitrator will have no power to add to, subtract from, or modify any of the terms of the ESP, or to change or add to any benefits provided by the ESP, or to waive or fail to apply any requirements of eligibility for a benefit under the ESP. Nonetheless, the arbitrator will have absolute discretion in the exercise of its powers in the ESP. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the ESP.

4.8 Receipt and Release of Necessary Information. In implementing the terms of the ESP, the RPAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the RPAC or Plan Administrator deems to be necessary for such purposes. Any Covered Executive or estate claiming benefits under the ESP will furnish to the RPAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

4.9 Overpayment and Underpayment of Benefits. The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Covered

Executive or his estate receives an underpayment of benefits, the Plan Administrator will direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Covered Executive or his estate, for whatever reason, the Plan Administrator may, in its sole and absolute discretion, withhold payment of any further benefits under the ESP until the overpayment has been collected or may require repayment of benefits paid under the ESP without regard to further benefits to which the Covered Executive or his estate may be entitled.

End of Article IV

ARTICLE V
OTHER BENEFIT PLANS OF THE COMPANY

5.1 Other Plans. Nothing contained in the ESP will prevent a Covered Executive before his death, or a Covered Executive's spouse or other beneficiary after such Covered Executive's death, from receiving, in addition to any payments provided for under the ESP, any payments provided for under any other plan or benefit program of the Employer, or which would otherwise be payable or distributable to him, his surviving spouse or beneficiary under any plan or policy of the Employer or otherwise. Nothing in the ESP will be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees and/or members of the Board.

5.2 Controlling Document. In the event that the provisions of any other plan or benefit program of the Employer conflict with any of the provisions contained in the ESP, the provisions of the ESP will control.

End of Article V

ARTICLE VI
AMENDMENT AND TERMINATION OF THE ESP

6.1 Continuation. The Company intends to continue the ESP indefinitely, but nevertheless assumes no contractual obligation beyond the promise to pay the benefits described in the ESP after such benefits have accrued.

6.2 Amendment of ESP. The Company, through an action of the Human Resources Committee may amend the ESP in its sole and absolute discretion, in any respect and at any time; provided, that no amendment may be made that reduces or diminishes the rights of any Covered Executive to the benefits described herein unless the affected Covered Executive receives at least one (1) year's advance notice of such amendment. Further, such advance notice to the Covered Executive will not be effective to enable the amendment of the ESP in either of the following two scenarios (a) if a Potential Change of Control occurs during the one (1) year notice period, or (b) within twenty four (24) months following a Change of Control.

6.3 Termination of ESP. The Company, through an action of the Human Resources Committee, may terminate or suspend the ESP in whole or in part at any time subject to the rules regarding the amendment of the ESP in Section 6.2 (*i.e.*, that one (1) year's advance notice is required and no such notice will be effective to enable the termination of the ESP if a Potential Change of Control occurs during the one (1) year notice period or within twenty four (24) months following a Change of Control). Notwithstanding any provision of the ESP to the contrary, upon the complete termination of the ESP pursuant to the provisions of this Section 6.3, the Human Resources Committee, in its sole and absolute discretion, may direct that the Plan Administrator treat each Eligible Executive as having incurred a Qualifying Termination and to commence the distribution of the benefits described in Article III to each such Eligible Executive or his estate, as applicable, to the extent that the commencement of such distribution comports with the requirements of section 409A of the Code.

6.4 Termination of Affiliate's Participation. Subject to the period relating to a Change of Control or Potential Change of Control described in Section 6.2, the Company may terminate an Affiliate's participation in the ESP at any time by an action of the Human Resources Committee and providing written notice to the Affiliate. The effective date of any such termination will be the later of the date specified in the notice of the termination of participation or the date on which the Plan Administrator can administratively implement such termination. If an Affiliate is disposed of by the Company pursuant to a stock or asset sale and a Covered Executive employed by such Affiliate is offered a comparable position with the purchaser of such stock or assets and refuses such position, the Covered Executive will not have incurred a Qualifying Termination for purposes of the ESP. Similarly, if an Affiliate is disposed of by the Company pursuant to a stock or asset sale and a Covered Executive employed by such Affiliate is offered a comparable position with the purchaser of such stock or assets and accepts such position, the Covered Executive will not have incurred a Qualifying Termination for purposes of the ESP.

End of Article VI

ARTICLE VII
MISCELLANEOUS

7.1 No Reduction of Employer Rights. Nothing contained in the ESP will be construed as a contract of employment between the Employer and a Covered Executive, or as a right of any Covered Executive to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Covered Executives, with or without cause.

7.2 Successor to the Company. The Company will require any successor or assign (whether direct or indirect, by purchase, exchange, lease, merger, consolidation, or otherwise) to all or substantially all of the property and assets of the Company and its Affiliates taken as a whole, to expressly assume the ESP and to agree to perform under this ESP in the same manner and to the same extent that the Company and its Affiliates would be required to perform it if no such succession had taken place. This Section 7.2 will not require any successor or assign of an Affiliate (whether direct or indirect, by purchase, exchange, lease, merger, consolidation or otherwise) to all or substantially all of the property and assets of such Affiliate to continue the ESP.

7.3 Provisions Binding. All of the provisions of the ESP will be binding upon the Company and its Affiliates and any successor to the Company or any such Affiliate. Likewise, the provisions of the ESP will be binding upon all persons who will be entitled to any benefit hereunder, their heirs and personal representatives.

End of Article VII

IN WITNESS WHEREOF, this Tenet Fifth Amended and Restated Executive Severance Plan has been executed this 12th day of January, 2021 effective as of February 1, 2021, except as specifically provided otherwise herein.

TENET HEALTHCARE CORPORATION

By: /s/ Kelly Pool

Kelly Pool, Vice President, Total Rewards

APPENDIX A
ESP AGREEMENTS

Section 2.1(s) of the Tenet Executive Severance Plan (the "**ESP**") provides that each Covered Executive will enter into an ESP Agreement which sets forth the terms and conditions of his benefits under the ESP and a form copy of such agreement will be attached to the ESP as Appendix A.

TENET EXECUTIVE SEVERANCE PLAN AGREEMENT*

THIS EXECUTIVE SEVERANCE PLAN AGREEMENT is made as of _____, 20__ by and between the Plan Administrator of the Tenet Executive Severance Plan (the "**ESP**") on behalf of _____ (the "**Employer**"), and _____ (the "**Covered Executive**"). Capitalized terms used in this Agreement that are not defined herein will have the meaning set forth in the ESP.

1. Severance Pay with respect to the Covered Executive means _____. *[Note to Drafter: either state it means the same thing as in the ESP or spell out definition that will apply.]*

2. The Severance Period for the Covered Executive will be _____ with respect to a Qualifying Termination that occurs outside the Protection Period and _____ with respect to a Qualifying Termination that occurs during the Protection Period. *[Note to Drafter if periods selected vary from existing tables check to make sure new periods comply with section 409A.]*

3. As a condition of obtaining benefits under the ESP the Covered Executive agrees to comply with the restrictive covenants set forth in Section 3.7 of the ESP.

4. Any dispute or claim for benefits under the ESP must be resolved through the claims procedure set forth in Article IV of the ESP which procedure culminates in binding arbitration. By accepting the benefits provided under the ESP, the Covered Executive hereby agrees to binding arbitration as the final means of dispute resolution with respect to the ESP.

5. The ESP is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties will be bound by and have the benefit of each and every provision of the ESP, as amended from time to time.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on _____, 20___.

COVERED EXECUTIVE	**EMPLOYER**
_____	_____
Covered Executive Name & Title	By: Kelly Pool, Plan Administrator

*Used for Participants who entered the ESP before the execution date of the Tenet Fourth Amended and Restated Executive Severance Plan (i.e., August 9, 2018) and whose participation has continued uninterrupted (i.e., are grandfathered). This Agreement is re-used for grandfathered Participants who have a change in title.

TENET EXECUTIVE SEVERANCE PLAN AGREEMENT*

THIS EXECUTIVE SEVERANCE PLAN AGREEMENT is made as of **DATE** by and between the Plan Administrator of the Tenet Executive Severance Plan (the "**ESP**") on behalf of [**Tenet Business Services Corporation][Tenet Employment, Inc.]** (the "**Employer**"), and **NAME** (the "**Covered Executive**"). Capitalized terms used in this Agreement that are not defined herein will have the meaning set forth in the ESP.

1. Severance Pay with respect to the Covered Executive base salary and average bonus as defined in Section 2.1(kk)(ii) of the ESP.

2. The Severance Period for the Covered Executive will be one (1) year with respect to a Qualifying Termination that occurs outside the Protection Period and one and one-half (1.5) years with respect to a Qualifying Termination that occurs during the Protection Period. [*Note to Drafter: alternatively may insert periods in Section 2.1(ll)(i)(A) and Section 2.1(ll)(i)(B) of the ESP based on the position of the Covered Executive as determined by the Plan Administrator or Executive Vice President, Human Resources*.]

3. As a condition of obtaining benefits under the ESP the Covered Executive agrees to comply with the restrictive covenants set forth in Section 3.7 of the ESP.

4. Any dispute or claim for benefits under the ESP must be resolved through the claims procedure set forth in Article IV of the ESP which procedure culminates in binding arbitration. By accepting the benefits provided under the ESP, the Covered Executive hereby agrees to binding arbitration as the final means of dispute resolution with respect to the ESP.

5. The ESP is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties will be bound by and have the benefit of each and every provision of the ESP, as amended from time to time.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on _____, 20__.

COVERED EXECUTIVE	**EMPLOYER**
_____	_____
Covered Executive Name & Title	By: Kelly Pool, Plan Administrator

*Used for Participants who enter ESP on and after the execution date of the Tenet Fourth Amended and Restated Executive Severance Plan (i.e., August 9, 2018) and are not Tier I or Tier II Covered Executives.

TENET EXECUTIVE SEVERANCE PLAN AGREEMENT*

THIS EXECUTIVE SEVERANCE PLAN AGREEMENT is made as of **DATE** by and between the Plan Administrator of the Tenet Executive Severance Plan (the "**ESP**") on behalf of [**Tenet Business Services Corporation][Tenet Employment, Inc.]** (the "**Employer**"), and **NAME** (the "**Covered Executive**"), who is employed as a [Tier I Covered Executive][Tier II Covered Executive]. Capitalized terms used in this Agreement that are not defined herein will have the meaning set forth in the ESP.

1. Severance Pay with respect to the Covered Executive is the severance pay defined in Section 2.1(kk)(iii)(A) of the ESP with respect to a Qualifying Termination that occurs outside the Protection Period and as set forth in Section 2.1(kk)(iii)(B*)* with respect to a Qualifying Termination that occurs during the Protection Period.

2. The Severance Period for the Covered Executive will be the applicable period set forth in Section 2.1(ll)(iii)(A) with respect to a Qualifying Termination that occurs outside the Protection Period and as set forth in Section 2.1(ll)(iii)(B*)* with respect to a Qualifying Termination that occurs during the Protection Period.

3. As a condition of obtaining benefits under the ESP the Covered Executive agrees to comply with the restrictive covenants set forth in Section 3.7 of the ESP.

4. Any dispute or claim for benefits under the ESP must be resolved through the claims procedure set forth in Article IV of the ESP which procedure culminates in binding arbitration. By accepting the benefits provided under the ESP, the Covered Executive hereby agrees to binding arbitration as the final means of dispute resolution with respect to the ESP.

5. The ESP is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties will be bound by and have the benefit of each and every provision of the ESP, as amended from time to time.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on _____, 20__.

COVERED EXECUTIVE		**EMPLOYER**
_____		_____
Covered Executive Name & Title	By:	Kelly Pool, Plan Administrator

*Used for Participants first hired or promoted into a Tier I or Tier II Covered Position on and after February 1, 2021).

FIFTH AMENDED TENET HEALTHCARE CORPORATION

ANNUAL INCENTIVE PLAN

(As Amended and Restated Effective November 4, 2020)

1. Purpose

The purpose of this Tenet Healthcare Corporation Annual Incentive Plan is to provide incentives to enhance shareholder value and promote the attainment of significant business objectives of the Company by basing a portion of selected Employees' compensation on the achievement of financial, business and other performance criteria.

2. Definitions

(a) "**Affiliate**" means a corporation or other entity controlled by, controlling or under common control with, the Company, or an entity that is otherwise closely connected to the Company, as determined by the Committee.

(b) "**Award**" means any annual incentive award, payable in cash, made under the Plan, which award may be based on (1) the change (measured as a percentage or an amount) in any one or more Performance Criteria from one measurement period to another, (2) the difference (measured as a percentage or an amount) between (A) a specified target or budget amount of any one or more Performance Criteria and (B) the actual amount of such Performance Criteria, during any measurement period, (3) the extent to which a specified target or budget amount for any one or more Performance Criteria is met or exceeded during any measurement period, (4) the attained level (measured as a percentage or an amount) of any one or more Performance Criteria relative to a designated comparison group of companies or published or special index during any measurement period; or (5) any other award, including a discretionary award, that may be paid from time to time under the Plan.

(c) "**Award Schedule**" means the Award Schedule established pursuant to Section 5.

(d) "**Board**" means the Board of Directors of the Company.

(e) "**Business Unit**" means any existing or future facility, region, division, group, subsidiary or other unit within the Company or any Affiliate.

(f) "**Cause**" means

(A) when used in connection with a Qualifying Termination occurring during a Participant's Protection Period, the same meaning as set forth in Section 2.1(f)(2) of the ESP, with the term "Participant" replacing the term "Covered Executive" as used therein.

(B) when used in connection with a Qualifying Termination not occurring during a Participant's Protection Period:

(i) For any Participant who is a "Covered Executive" under the ESP, the same meaning as set forth in Section 2.1(f)(1) of the ESP, with the term "Participant" replacing the term "Covered Executive" as used therein.

(ii) For any Participant who is not a "Covered Executive" under the ESP, "Cause" shall mean a Participant's:

1. Dishonesty
2. Fraud;
3. Willful misconduct;
4. Breach of fiduciary duty;
5. Conflict of interest;
6. Commission of a felony;
7. Material failure or refusal to perform his or her job duties in accordance with Company policies;
8. Material violation of Company policy that causes harm to the Company or an Affiliate;
9. Other wrongful conduct of a similar nature and degree; or
10. Sustained unsatisfactory performance which is not improved after the Participant has been provided with a reasonable opportunity to improve his or her performance in accordance with the Company's standard policies and procedures.

(g) "**Change of Control**" has the same meaning as set forth in the definition of "Change of Control" in the ESP.

(h) "**Code**" means the Internal Revenue Code of 1986, as amended, and any successor statute and the regulations promulgated thereunder, as it or they may be amended from time to time.

(i) "**Committee**" means the Human Resources Committee of the Board or any subcommittee thereof formed by the Human Resources Committee for the purpose of acting as the Committee hereunder.

(j) **"Company**" means Tenet Healthcare Corporation, a Nevada corporation.

(k) "**Employee**" means any executive officer or other employee of the Company or any Affiliate, or of any of their respective Business Units.

(l) "**ESP**" means the Tenet Executive Severance Plan, as amended or restated from time to time.

(m) "**Good Reason**" means:

1. When used in connection with a Qualifying Termination occurring during a Participant's Protection Period, the same meaning as set forth in Section 2.1(x)(2) of the ESP.

2. When used in connection with a Qualifying Termination not occurring during a Participant's Protection Period, for any Participant who is a "Covered Executive" under the ESP, the same meaning as set forth in Section 2.1(x)(1) of the ESP. For the avoidance of doubt, a Participant who is not a "Covered Executive" under the ESP shall not be eligible to claim "Good Reason" hereunder with regard to any termination of employment occurring outside a Participant's Protection Period.

3. For purposes of this Section 2(m), references to "Employer" in the ESP with respect to any Participant means the Company or an Affiliate employing such Participant and references to "Covered Executive" in the ESP mean the Participant.

(n) "**Participant**" means any Employee selected to receive an Award under the Plan for any Year or other measurement period.

(o) "**Performance Criterion**" and "**Performance Criteria**" means any one or more of the following performance measures, or derivations of such performance measures, taken alone or in conjunction with each other, each of which may be adjusted by the Committee to exclude the before-tax or after-tax effects of any significant acquisitions or dispositions not included in the calculations made in connection with setting the Performance Criterion or Performance Criteria for the related Award or as otherwise deemed appropriate by the Committee, which adjustments need not be the same for each Participant, in each case as determined by and calculated or measured in the manner specified by the Committee:

(A) Basic or diluted earnings per share of common stock;

(B) Cash flow;

(C) Economic value added;

(D) Income, which may include, without limitation, net income, operating income, expense control measures, or other derivations of income;

(E) Volume measures (e.g., admissions or visits);

(F) Quality of service and/or patient care;

(G) Business performance or return measures (including, but not limited to, market share, debt reduction, return on assets, capital, equity, or sales);

(H) The price of the Company's common or preferred stock (including, but not limited to, growth measures and total shareholder return); or

(I) Any other criteria related to performance, including the performance of one or more of the Business Units, individual performance or any other category of performance selected by the Committee.

Any of the Performance Criteria may be applied to either the Company as a whole or any Business Unit, determined on an absolute or relative basis or as compared to the performance of a published or special index deemed applicable by the Committee including, but not limited to, the Russell 3000 Index or another group of companies deemed by the Committee to be comparable to the Company.

(p) "**Performance Goals**" means the performance objectives with respect to one Performance Criterion or two or more Performance Criteria established by the Committee for the purpose of determining whether, and the extent to which, payments will be made for that Year or other measurement period with respect to an Award under the Plan.

(q) "**Plan**" means the Tenet Healthcare Corporation Annual Incentive Plan as set forth herein, as it has been or may be amended and/or restated from time to time.

(r) "Protection Period" means:

(A) with respect to Participants who are not eligible to participate in the ESP, the period beginning on the date of a Change in Control and ending twenty-four (24) months following the occurrence of the Change in Control; and

(B) with respect to Participants who are eligible to participate in the ESP, the same "Protection Period" as set forth in the ESP, and as it may be amended from time to time.

(s) "**Qualifying Termination**" means a Participant's "separation from service" (within the meaning of Section 409A of the Code) by reason of:

(A) the involuntary termination of a Participant's employment by the Company (or an Affiliate) without Cause, or

(B) the Participant's resignation from the employment of the Company (or an Affiliate) for Good Reason;

provided, however, that a Qualifying Termination will not occur by reason of the divestiture of Business Unit with respect to a Participant employed by such Business Unit who is offered a comparable position with the purchaser (regardless of whether the Participant accepts such position).

(t) "**RPAC"** means the Retirement Plans Administration Committee of the Company.

(u) "**Scheduled Payment Date**" means the Year after the Year in which a measurement period (including a measurement period that coincides with a Year) ends with respect to which a Participant has met the applicable Performance Goals entitling such Participant to receive an Award under this Plan.

(v) "**Target Award**" means the amount, which may be expressed as a dollar amount or as a percentage of a Participant's salary, payable to a Participant when actual performance with respect to any one Performance Criterion or any two or more Performance Criteria equals the Performance Goals for that Performance Criterion or those Performance Criteria established by the Committee.

(w) "**Year**" means the Company's fiscal year.

3. Administration

(a) **Appointment of Committee**. The Plan shall be administered by the Committee. The Committee's determinations under the Plan need not be uniform and may be made by it selectively among persons who receive or are eligible to receive Awards under the Plan, whether or not any Awards are the same or such persons are similarly situated. Without limiting the generality of the foregoing, the Committee will be entitled, among other things, to make non-uniform and selective determinations and to establish non-uniform and selective Performance Criterion, Performance Criteria, Performance Goals, the weightings thereof, and Target Awards. Whenever the Plan refers to a determination being made by the Committee, it shall be deemed to mean a determination by the Committee in its sole discretion. Notwithstanding the foregoing, the Committee may delegate the responsibility for administering the Plan, subject to such limitations as the Committee deems appropriate. All references in the Plan to the "Committee" shall be, as applicable, to the Committee or any other committee or officer to whom the Board or the Committee has delegated authority to administer the Plan.

(b) **Discretion of Committee**. The Committee shall have the discretion, subject to the limitations described herein, to, among other actions, (1) determine the Plan Participants; (2) determine the measurement period; (3) determine Performance Criterion, Performance Goals and Target Awards for each Year or other measurement period; (4) determine how Performance Criteria will be calculated and/or adjusted; (5) establish an Award Schedule; (6) establish performance thresholds for the payment of any Awards; (7) determine whether and to what extent the Performance Goals have been met or exceeded; (8) pay discretionary

Awards, including awards from an exceptional performance fund, as may be appropriate in order to assure the proper motivation and retention of personnel and attainment of business goals; (9) make adjustments to Performance Goals and thresholds; and (10) determine the total amount of funds available for payment of Awards with respect to each Year or other measurement period.

(c) Authority of Committee. Subject to the provisions of the Plan, the Committee shall be authorized to interpret the Plan, make, amend and rescind such rules as it deems necessary for the proper administration of the Plan, make all other determinations necessary or advisable for the administration of the Plan and correct any defect or supply any omission or reconcile any inconsistency in the Plan in the manner and to the extent the Committee deems desirable to carry the Plan into effect. Any action taken or determination made by the Committee shall be conclusive and binding on all parties. In the event of any conflict between an Award Schedule and the Plan, the terms of the Plan shall govern.

4. Adjustments for Material Changes

In the event of (1) a change in corporate capitalization, a corporate transaction or a complete or partial corporate liquidation, or (2) a natural disaster or other significant unforeseen event that materially impacts the operation of the Company, or (3) other material items that are treated under generally accepted accounting principles as unusual in nature or infrequently occurring, or (4) any material change in accounting policies or practices affecting the Company and/or the Performance Goals, then, to the extent any of the foregoing items or events was not anticipated at the time the Performance Goals were established, the Committee may in each case appropriately adjust any evaluation of performance under such Performance Goals so as to neutralize the effect of the item or event on the applicable Award.

5. Award Schedules

The Committee may establish a Performance Criterion or two or more Performance Criteria and Performance Goals for each Year or other measurement period. If the Committee establishes two or more Performance Criteria, the Committee may in its discretion determine the weight to be given to each Performance Criteria in determining Awards. The Committee shall establish an Award Schedule for each Participant for each Year, which Award Schedule shall set forth the Target Award for such Participant payable at specified levels of performance, based on the Performance Goal for each Performance Criterion and the weighting, if any, established for such criterion. The Committee may vary the Performance Criteria, Performance Goals and weightings, if any, from Participant to Participant, Award to Award, Year to Year and measurement period to measurement period.

6. Eligible Persons

Any Employee who is a key Employee in the judgment of the Committee shall be eligible to be selected by the Committee to participate in the Plan. Board members who are not Employees are not eligible to participate in the Plan. No Employee shall have a right to be selected to participate in the Plan, or, having once been selected, to be selected again, or to continue as an Employee.

7. Amount Available for Awards

The Committee shall determine the amount available for payment of Awards in any Year or any other measurement period.

8. Determination of Awards

The Committee shall determine the actual Award payable to each Participant for each Year or other measurement period, taking into consideration, as it deems appropriate, the performance of the Company, Affiliate and/or a Business Unit, as the case may be, for the Year or other measurement period in relation to the Performance Goals theretofore established by the Committee, and the performance of the respective Participants during the Year or other measurement period. The fact that an Employee is selected as a Participant for any Year or other measurement period shall not mean that such Employee necessarily will receive an Award for that Year or other measurement period. The Committee may, in its discretion, increase or reduce the amount of an Award otherwise earned hereunder after considering such factors as it deems appropriate, including individual performance factors. Notwithstanding any other provisions of the Plan to the contrary, the Committee may grant discretionary Awards as it sees fit under the Plan.

9. Payment of Awards

Awards under the Plan for a particular Year or other measurement period shall be paid on the Scheduled Payment Date with respect to such Year (or other measurement period), unless the time of payment is otherwise specified in an Award Schedule; provided, however, that any alternate time of payment provided for in an Award Schedule must comply with the requirements of section 409A of the Code.

10. Repayment and Forfeiture of Awards

To the extent permitted by governing law, the Board may require forfeiture of all or part of any unpaid Awards or reimbursement to the Company of Awards paid to any Participant who is an executive officer of the Company where (a) the payment was predicated in whole or in part upon the achievement of certain financial results that were subsequently the subject of a material restatement, (b) in the Board's view the officer engaged in fraud or misconduct that caused or partially caused the need for the restatement, and (c) a lower Award payment would have been made to the officer based upon the restated financial results.

In each such instance, the Company will, as directed by the Board and to the extent practicable, cancel all or part of any outstanding unpaid Award or seek to recover the amount by which the individual officer's Award for the relevant period exceeded the lower Award payment that would have been made based on the restated financial results, plus a reasonable rate of interest; provided that the Company will not seek to recover Awards paid more than five years prior to the date the applicable restatement is disclosed.

To the extent permitted by governing law, the Company may require forfeiture of all or part of any unpaid Awards or seek reimbursement of Awards paid to any Participant in other circumstances involving material violations of any Company policy, fraud or misconduct by the Participant where the Board determines that such violations, fraud or misconduct caused substantial harm to the Company even in the absence of a subsequent restatement of the Company's financial statements.

In addition, Awards paid under this Plan will be subject to recoupment in accordance with any other recoupment policy that the Company adopts or is required to adopt pursuant to the listing standards of any national securities exchange or association on which the Company's securities are listed, the Dodd-Frank Wall Street Reform and Consumer Protection Act, or other applicable law.

No forfeiture or recovery of compensation under this Section 10 will be an event giving rise to a right to resign for "good reason" or "constructive termination" (or similar term) under any Company plan or agreement with the Company.

11. Termination of Employment

(a) **General Rule**. Except as provided in Subsections (b) and (c) below, a Participant must be actively employed by the Company on the date the amount payable with respect to his/her Award is determined by the Committee (the "**Determination Date**") in order to be entitled to payment of any Award for that Year or other measurement period. A Participant who terminates employment with the Company prior to the Determination Date under any circumstances other than those set forth in Subsections (b) and (c) shall not be entitled to receive any Award for the Year or other measurement period in which such termination of employment occurs.

(b) **Exception for a Termination of Employment by the Participant for Good Reason or by the Company without Cause on or after Completion of at Least 50% of Measurement Period**. In the event active employment of a Participant shall be terminated before the Determination Date but on or after the date that at least 50% of the measurement period for the Award has been completed (e.g., on or after July 1 for a calendar year measurement period) (1) by the Participant for Good Reason or (2) by the Company without Cause, such Participant will receive a portion of his/her Award for the Year (or other applicable measurement period), calculated from the beginning of the Year (or other applicable measurement period) through the date of such Participant's termination of employment with the Company, pro-rated as a fraction based on the full number of months worked by the

Participant for the Company or an Affiliate during the relevant measurement period; provided, however, that in order to receive a pro-rata portion of an Award under this Section 11(b), a Participant must meet the Performance Criterion (or Performance Criteria) and/or Performance Goals established by the Committee with respect to such Award for the period from the beginning of the Year (or other applicable measuring period) through the end of the Year (or other applicable measurement period).

(c) **Exception for a Termination of Employment due to Retirement**. In the event of a Participant's retirement before the Determination Date, such Participant will receive a portion of his/her Award for the Year (or other applicable measurement period), calculated from the beginning of the Year (or other applicable measurement period) through the date of such Participant's termination of employment with the Company, pro-rated as a fraction of based on the number of full months worked by the Participant for the Company or an Affiliate during such measurement period; provided, however, that in order to receive a pro-rata portion of an Award under this Section 11(c), a Participant must meet the Performance Criterion (or Performance Criteria) and/or Performance Goals established by the Committee with respect to such Award for the period from the beginning of the Year (or other applicable measuring period) through the end of the Year (or other applicable measurement period). For purposes of this Section 11(c), a "retirement" means a termination of employment by the Participant on or after age 62.

12. Miscellaneous

(a) **Nonassignability**. No Award will be assignable or transferable without the written consent of the Committee in its sole discretion, except by will or by the laws of descent and distribution.

(b) **Withholding Taxes**. Whenever payments under the Plan are to be made, the Company will withhold therefrom an amount sufficient to satisfy any applicable governmental withholding tax requirements related thereto.

(c) **Amendment or Termination of the Plan**. The Committee may at any time amend, suspend or discontinue the Plan, in whole or in part. The Committee may at any time alter or amend any or all Award Schedules under the Plan to the extent permitted by law. Notwithstanding the foregoing, the RPAC has the right to make non-material amendments to the Plan to comply with changes in the law or to facilitate Plan administration; provided, however, that each such proposed non-material amendment must be discussed with the Chairperson of the Committee in order to determine whether such change would constitute a material amendment to the Plan. No Participant shall have any guarantee of or right to payment with respect to any Award hereunder at any time.

(d) **Other Payments or Awards**. Nothing contained in the Plan will be deemed in any way to limit or restrict the Company from making any Award or payment to any

person under any other plan, arrangement or understanding, whether now existing or hereafter in effect.

(e) **Payments to Other Persons**. If payments are legally required to be made to any person other than the person to whom any amount is available under the Plan, payments will be made accordingly. Any such payment will be a complete discharge of the liability of the Company.

(f) **Limits of Liability**.

1. Any liability of the Company to any Participant with respect to an Award shall be based solely upon the obligations, if any, created by the Plan and the Award Schedule.

2. Neither the Company, nor any member of its Board or of the Committee, nor any other person participating in any determination of any question under the Plan, or in the interpretation, administration or application of the Plan, shall have any liability to any party for any action taken or not taken in good faith under the Plan.

(g) **Rights of Employees.**

1. Status as an Employee eligible to receive an Award under the Plan shall not be construed as a commitment that any Award will be made under this Plan to such Employee or to other such Employees generally.

2. Nothing contained in this Plan or in any Award Schedule (or in any other documents related to this Plan or to any Award or Award Schedule) shall confer upon any Employee or Participant any right to continue in the employ or other service of the Company or constitute a contract or limit in any way the right of the Company to change such person's compensation or other benefits or to terminate the employment or other service of such person with or without cause.

(h) **Section Headings**. The section headings contained herein are for the purposes of convenience only, and in the event of any conflict, the text of the Plan, rather than the section headings, will control.

(i) I**nvalidity**. If any term or provision contained herein will to any extent be invalid or unenforceable, such term or provision will be reformed so that it is valid, and such invalidity or unenforceability will not affect any other provision or part hereof.

(j) **Applicable Law**. The Plan, Awards and Award Schedules and all actions taken hereunder or thereunder shall be governed by, and construed in accordance with, the laws of the state of Texas without regard to the conflict of law principles thereof.

(k) **Compliance with Section 409A of the Code**. The Plan is intended to be exempt from or comply with section 409A of the Code and shall be administered in such a

manner and shall be construed and interpreted in accordance with such intent To the extent that an Award or the payment of such Award is subject to section 409A of the Code, the Award shall be granted and paid in a manner that will comply with section 409A of the Code, including regulations or other guidance issued with respect thereto, except as otherwise determined by the Committee. Any provision of this Plan that would cause the grant of an Award or the payment of such Award to fail to satisfy section 409A of the Code may be amended, in the discretion of the Committee, to comply with section 409A of the Code on a timely basis, and may be amended on a retroactive basis, in accordance with regulations and other guidance issued under section 409A of the Code.

(l) **Conflicts Between Plans**. In the event that there is a conflict between a provision of this Plan and the ESP, as then in effect, the terms of the ESP shall control.

(m) **Arbitration**. In the event of a dispute arising under this Plan, a Participant or the Company, as applicable, may submit a claim to a third party neutral arbitrator. The arbitration will be conducted pursuant to the American Arbitration Association ("AAA") Rules on Employee Benefit Claims.

The arbitrator will be mutually selected by the Participant and the Company and/or the RPAC from a list of arbitrators who are experienced in employee compensation matters that is provided by the AAA. If the parties are unable to agree on the selection of an arbitrator within ten (10) days of receiving the list from the AAA, the AAA will appoint an arbitrator. The arbitrator's review will be limited to interpretation of the Plan document in the context of the particular facts involved. The Participant, the RPAC and the Company agree to accept the award of the arbitrator as binding, and all exercises of power by the arbitrator hereunder will be final, conclusive and binding on all interested parties, unless found by a court of competent jurisdiction, in a final judgment that is no longer subject to review or appeal, to be arbitrary and capricious. The Participant, the RPAC and the Company agree that the venue for the arbitration will be in Dallas, Texas. The costs of arbitration will be paid by the Company; the costs of legal representation for the Participant or witness costs for the Participant will be borne by the Participant; provided, that, as part of his award, the arbitrator may require the Company to reimburse the Participant for all or a portion of such amounts.

The following discovery may be conducted by the parties: interrogatories, demands to produce documents, requests for admissions and oral depositions. The arbitrator will resolve any discovery disputes by such pre-hearing conferences as may be needed. The Company, the RPAC and Participant agree that the arbitrator will have the power of subpoena process as provided by law. Disagreements concerning the scope of depositions or document production, its reasonableness and enforcement of discovery requests will be subject to agreement by the Company and the Participant or will be resolved by the arbitrator. All discovery requests will be subject to the proprietary rights and rights of privilege and other protections granted by applicable

law to the Company and the Participant and the arbitrator will adopt procedures to protect such rights. With respect to any dispute, the Company, the RPAC and the Participant agree that all discovery activities will be expressly limited to matters directly relevant to the dispute and the arbitrator will be required to fully enforce this requirement. The arbitrator will have no power to add to, subtract from, or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. Nonetheless, the arbitrator will have absolute discretion in the exercise of its powers in the Plan. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the Plan.

(n) **Successors**. All obligations of the Company under the Plan with respect to Awards shall be binding on any successor to the Company, whether the existence of such successor is the result of a direct or indirect purchase, merger, consolidation, or otherwise, of all or substantially all the business and/or assets of the Company.

Subsidiaries
of
Tenet Healthcare Corporation
as of December 31, 2020

Name of Entity	State or Other Jurisdiction of Formation
601 N 30th Street I, L.L.C.	Delaware
601 N 30th Street II, L.L.C.	Nebraska
601 N 30th Street III, Inc.	Nebraska
The 6300 West Roosevelt Partnership	Illinois
Abrazo Health Network EP Clinical Services, LLC	Arizona
Advantage Health Care Management Company, LLC	Delaware
Advantage Health Network, Inc.	Florida
AHM Acquisition Co., Inc.	Delaware
Alabama Cardiovascular Associates, L.L.C.	Alabama
Alabama Hand and Sports Medicine, L.L.C.	Alabama
Allegian Insurance Company	Texas
Alvarado Hospital Medical Center, Inc.	California
AMC/North Fulton Urgent Care #1, L.L.C.	Georgia
AMC/North Fulton Urgent Care #2, L.L.C.	Georgia
AMC/North Fulton Urgent Care #3, L.L.C.	Georgia
AMC/North Fulton Urgent Care #4, L.L.C.	Georgia
AMC/North Fulton Urgent Care #5, L.L.C.	Georgia
American Medical (Central), Inc.	California
AMI/HTI Tarzana Encino Joint Venture	Delaware
AMI Information Systems Group, Inc.	California
Amisub (Heights), Inc.	Delaware
Amisub (Hilton Head), Inc.	South Carolina
Amisub (North Ridge Hospital), Inc.	Florida
Amisub of California, Inc.	California
Amisub of North Carolina, Inc.	North Carolina
Amisub of South Carolina, Inc.	South Carolina
Amisub of Texas, Inc.	Delaware
Amisub (SFH), Inc.	Tennessee
Amisub (Twelve Oaks), Inc.	Delaware
Anaheim MRI Holding, Inc.	California
Arizona Care Network – Next, L.L.C.	Arizona
Arizona Health Partners, LLC	Arizona
Asia Outsourcing US, Inc.	Delaware
Atlanta Medical Center, Inc.	Georgia
Atlanta Medical Center Interventional Neurology Associates, L.L.C.	Georgia
Atlanta Medical Center Neurosurgical & Spine Specialists, L.L.C.	Georgia
Atlanta Medical Center Physician Group, L.L.C.	Georgia

Baptist Accountable Care, LLC	Texas
Baptist Diagnostics, LLC	Delaware
Baptist Health Centers, LLC	Delaware
Baptist Physician Alliance ACO, LLC	Alabama
Baptist Physician Alliance, LLC	Alabama
BBH BMC, LLC	Delaware
BBH CBMC, LLC	Delaware
BBH DevelopmentCo, LLC	Delaware
BBH NP Clinicians, Inc.	Delaware
BBH PBMC, LLC	Delaware
BBH SBMC, LLC	Delaware
BBH WBMC, LLC	Delaware
BCDC EmployeeCO, LLC	Delaware
BHC-Talladega Pediatrics, LLC	Alabama
BHS Accountable Care, LLC	Delaware
BHS Affinity, LLC	Delaware
BHS Integrated Physician Partners, LLC	Delaware
BHS Physician Performance Network, LLC	Delaware
BHS Physicians Alliance for ACE, LLC	Delaware
BHS Physicians Network, Inc.	Texas
BHS Specialty Network, Inc.	Texas
Bluffton Okatie Primary Care, L.L.C.	South Carolina
Broad River Primary Care, L.L.C.	South Carolina
Brookwood Ancillary Holdings, Inc.	Delaware
Brookwood Baptist Health 1, LLC	Delaware
Brookwood Baptist Health 2, LLC	Delaware
Brookwood Baptist Imaging, LLC	Delaware
Brookwood Center Development Corporation	Alabama
Brookwood Development, Inc.	Alabama
Brookwood Garages, L.L.C.	Alabama
Brookwood Health Services, Inc.	Alabama
Brookwood Home Health, LLC	Alabama
Brookwood - Maternal Fetal Medicine, L.L.C.	Alabama
Brookwood Occupational Health Clinic, L.L.C.	Alabama
Brookwood Parking Associates, Ltd.	Alabama
Brookwood Primary Care Cahaba Heights, L.L.C.	Alabama
Brookwood Primary Care - Homewood, L.L.C.	Alabama
Brookwood Primary Care Hoover, L.L.C.	Alabama
Brookwood Primary Care - Inverness, L.L.C.	Alabama
Brookwood Primary Care - Mountain Brook, L.L.C.	Alabama
Brookwood Primary Care - Oak Mountain, L.L.C.	Alabama
Brookwood Primary Care The Narrows, L.L.C.	Alabama

Brookwood Primary Care - Vestavia, L.L.C.	Alabama
Brookwood Primary Network Care, Inc.	Alabama
Brookwood Specialty Care - Endocrinology, L.L.C.	Alabama
Brookwood Sports and Orthopedics, L.L.C.	Alabama
Brookwood Women's Care, L.L.C.	Alabama
BT East Dallas JV, LLP	Texas
BW Cardiology, LLC	Delaware
BW Cyberknife, LLC	Delaware
BW Hand Practice, LLC	Delaware
BW Office Buildings, LLC	Delaware
BW Parking Decks, LLC	Delaware
BW Physician Practices, LLC	Delaware
BW Retail Pharmacy, LLC	Delaware
BW Sports Practice, LLC	Delaware
C7 Technologies, LLC	Delaware
Camp Creek Urgent Care, L.L.C.	Georgia
Captive Insurance Services, Inc.	Delaware
Cardiology Physicians Associates, L.L.C.	North Carolina
Cardiology Physicians Corporation, L.L.C.	North Carolina
Cardiovascular & Thoracic Surgery Associates, L.L.C.	South Carolina
Cardiovascular Clinical Excellence at Sierra Providence, LLC	Texas
Catawba-Piedmont Cardiothoracic Surgery, L.L.C.	South Carolina
Cedar Hill Primary Care, L.L.C.	Missouri
Center for Advanced Research Excellence, L.L.C.	Florida
Center for the Urban Child, Inc.	Pennsylvania
Central Carolina-IMA, L.L.C.	North Carolina
Central Carolina Physicians - Sandhills, L.L.C.	North Carolina
Central Valley Quality Alliance, LLC	Delaware
Central Texas Corridor Hospital Company, LLC	Delaware
CGH Hospital, Ltd.	Florida
Chalon Living, Inc.	Arizona
Children's Hospital of Michigan Premier Network, Inc.	Michigan
CHN Holdings, LLC	Delaware
CHVI Tucson Holdings, LLC	Delaware
CML-Chicago Market Labs, Inc.	Delaware
Coast Healthcare Management, LLC	California
Coastal Carolina Medical Center, Inc.	South Carolina
Coastal Carolina Physician Practices, LLC	Delaware
Coastal Carolina Pro Fee Billing, L.L.C.	South Carolina
Commonwealth Continental Health Care, Inc.	Florida
Community Connection Health Plan, Inc.	Arizona
Community Hospital of Los Gatos, Inc.	California

Conifer Care Continuum Solutions, LLC	Maryland
Conifer Ethics and Compliance, Inc.	Delaware
Conifer Global Business Center, Inc.	Republic of the Philippines
Conifer Global Holdings, Inc.	Delaware
Conifer Health Solutions, LLC	Delaware
Conifer Holdings, Inc.	Delaware
Conifer Patient Communications, LLC	Florida
Conifer Physician Services Holdings, Inc.	Delaware
Conifer Physician Services, Inc.	Illinois
Conifer Revenue Cycle Solutions, LLC	California
Conifer Value-Based Care, LLC	Maryland
Coral Gables Hospital, Inc.	Florida
CRNAs of Michigan	Michigan
Delray Medical Center, Inc.	Florida
Delray Medical Physician Services, L.L.C.	Florida
Desert Regional Medical Center, Inc.	California
Des Peres Physician Network, LLC	Missouri
Detroit Education & Research	Michigan
DigitalMed, Inc.	Delaware
Dignity/Abrazo Health Network, LLC	Arizona
DMC Detroit Receiving Hospital Premier Clinical Co-Management Services, LLC	Michigan
DMC Education & Research	Michigan
DMC Harper University Hospital Premier Clinical Co-Management Services, LLC	Michigan
DMC Huron Valley-Sinai Hospital Premier Clinical Management Services, LLC	Michigan
DMC Imaging, L.L.C.	Florida
Doctors Hospital of Manteca, Inc.	California
Doctors Medical Center Neurosciences Clinical Co-Management, LLC	California
Doctors Medical Center of Modesto, Inc.	California
Doctors Medical Center Orthopedics Clinical Co-Management, LLC	California
East Cobb Urgent Care, LLC	Georgia
East Cooper Coastal Family Physicians, L.L.C.	South Carolina
East Cooper Community Hospital, Inc.	South Carolina
East Cooper Hyperbarics, L.L.C.	Delaware
East Cooper OB/GYN, L.L.C.	South Carolina
East Cooper Physician Network, LLC	South Carolina
East Cooper Primary Care Physicians, L.L.C.	South Carolina
EPHC, Inc.	Texas
First Choice Physician Partners	California
FMCC Network Contracting, L.L.C.	Florida
FMC Medical, Inc.	Florida
Fort Bend Clinical Services, Inc.	Texas

Fountain Valley Regional Hospital and Medical Center	California
Fountain Valley Surgery Center, LLC	California
FREH Real Estate, L.L.C.	Florida
FRS Imaging Services, L.L.C.	Florida
FryeCare Boone, L.L.C.	North Carolina
FryeCare Morganton, L.L.C.	North Carolina
FryeCare Physicians, L.L.C.	North Carolina
FryeCare Valdese, L.L.C.	North Carolina
FryeCare Watauga, L.L.C.	North Carolina
FryeCare Women's Services, L.L.C.	North Carolina
Frye Regional Medical Center, Inc.	North Carolina
Gardendale Surgical Associates, LLC	Alabama
Gastric Health Institute, L.L.C.	Georgia
Georgia Gifts From Grace, L.L.C.	Georgia
Georgia North Fulton Healthcare Associates, L.L.C.	Georgia
Georgia Northside Ear, Nose and Throat, L.L.C.	Georgia
Georgia Physicians of Cardiology, L.L.C.	Georgia
Georgia Spectrum Neurosurgical Specialists, L.L.C.	Georgia
Good Samaritan Medical Center, Inc.	Florida
Good Samaritan Surgery, L.L.C.	Florida
Graystone Family Healthcare - Tenet North Carolina, L.L.C.	North Carolina
Greater Dallas Healthcare Enterprises	Texas
Greater Northwest Houston Enterprises	Texas
Greystone Internal Medicine - Brookwood, L.L.C.	Alabama
Gulf Coast Community Hospital, Inc.	Mississippi
Hardeeville Medical Group, L.L.C.	South Carolina
Hardeeville Primary Care, L.L.C.	South Carolina
Harlingen Physician Network, Inc.	Texas
Harper-Hutzel AHP Services, Inc.	Michigan
HCH Tucson Holdings, LLC	Delaware
HCN Emerus Management Sub, LLC	Texas
HCN Emerus Texas, LLC	Texas
HCN Laboratories, Inc.	Texas
HCN Physicians, Inc.	Texas
HCN Surgery Center Holdings, Inc.	Delaware
HDMC Holdings, L.L.C.	Delaware
Health & Wellness Surgery Center, L.P.	California
Healthcare Compliance, LLC	District of Columbia
The Healthcare Insurance Corporation	Cayman Islands
Healthcare Network Alabama, Inc.	Delaware
Healthcare Network CFMC, Inc.	Delaware
Healthcare Network DPH, Inc.	Missouri

Healthcare Network Georgia, Inc.	Delaware
Healthcare Network Holdings, Inc.	Delaware
Healthcare Network Hospitals (Dallas), Inc.	Delaware
Healthcare Network Hospitals, Inc.	Delaware
Healthcare Network Louisiana, Inc.	Delaware
Healthcare Network Missouri, Inc.	Delaware
Healthcare Network North Carolina, Inc.	Delaware
Healthcare Network South Carolina, Inc.	Delaware
Healthcare Network Tennessee, Inc.	Delaware
Healthcare Network Texas, Inc.	Delaware
The Healthcare Underwriting Company, a Risk Retention Group	Vermont
HealthCorp Network, Inc.	Delaware
Healthpoint of North Carolina, L.L.C.	North Carolina
Health Services CFMC, Inc.	Texas
Health Services HNMC, Inc.	Delaware
Health Services Network Care, Inc.	Delaware
Health Services Network Hospitals, Inc.	Delaware
Health Services Network Texas, Inc.	Delaware
Heart and Vascular Institute of Michigan	Michigan
Hialeah Hospital, Inc.	Florida
Hialeah Real Properties, Inc.	Florida
Hickory Family Practice Associates - Tenet North Carolina, L.L.C.	North Carolina
Hilton Head Health System, L.P.	South Carolina
Hilton Head Regional Healthcare, L.L.C.	South Carolina
Hilton Head Regional OB/GYN Partners, L.L.C.	South Carolina
Hilton Head Regional Physician Network – Georgia, L.L.C.	Georgia
Hilton Head Regional Physician Network, LLC	South Carolina
Hitchcock State Street Real Estate, Inc.	California
HNMC, Inc.	Delaware
HNW GP, Inc.	Delaware
HNW LP, Inc.	Delaware
Holy Cross Hospital, Inc.	Arizona
Home Health Partners of San Antonio, LLC	Texas
Hoover Doctors Group, Inc.	Alabama
Hoover Land, LLC	Delaware
Hospital Development of West Phoenix, Inc.	Delaware
Hospital RCM Services, LLC	Texas
Hospital Underwriting Group, Inc.	Tennessee
Houston Northwest Partners, Ltd.	Texas
Houston Specialty Hospital, Inc.	Texas
Houston Sunrise Investors, Inc.	Delaware
HSRM International, Inc.	California

HUG Services, Inc.	Delaware
The Huron Corporation	District of Columbia
Imaging Center at Baxter Village, L.L.C.	South Carolina
InforMed Insurance Services, LLC	Maryland
International Health and Wellness, Inc.	Florida
JFK Memorial Hospital, Inc.	California
Journey Home Healthcare of San Antonio, LLC	Texas
Laguna Medical Systems, Inc.	California
Lake Health Care Facilities Inc.	Delaware
LakeFront Medical Associates, LLC	Delaware
Lakewood Regional Medical Center, Inc.	California
Lifemark Hospitals, Inc.	Delaware
Lifemark Hospitals of Florida, Inc.	Florida
Lifemark Hospitals of Louisiana, Inc.	Louisiana
Los Alamitos Medical Center, Inc.	California
MacNeal Management Services, Inc.	Illinois
MacNeal Medical Records, Inc.	Delaware
MacNeal Physicians Group, LLC	Delaware
Meadowcrest Hospital, LLC	Louisiana
Medplex Outpatient Medical Centers, Inc.	Alabama
Memphis Urgent Care #1, L.L.C.	Tennessee
Memphis Urgent Care #2, L.L.C.	Tennessee
MetroWest HomeCare & Hospice, LLC	Massachusetts
Michigan Pioneer ACO, LLC	Delaware
Michigan Regional Imaging, LLC	Michigan
Midwest Pharmacies, Inc.	Illinois
Mobile Imaging Management, LLC	Michigan
Mobile Technology Management, LLC	Michigan
Nacogdoches ASC-LP, Inc.	Delaware
National Ancillary, Inc.	Texas
National ASC, Inc.	Delaware
National Diagnostic Imaging Centers, Inc.	Texas
National HHC, Inc.	Texas
National Home Health Holdings, Inc.	Delaware
National ICN, Inc.	Texas
National Medical Services II, Inc.	Florida
National Outpatient Services Holdings, Inc.	Delaware
National Urgent Care Holdings, Inc.	Delaware
National Urgent Care, Inc.	Florida
Network Management Associates, Inc.	California
New Dimensions, LLC	Illinois
New England Physician Performance Network, LLC	Delaware

New H Acute, Inc.	Delaware
New Medical Horizons II, Ltd.	Texas
NMC Lessor, L.P.	Texas
NME Headquarters, Inc.	California
NME Properties Corp.	Tennessee
NME Properties, Inc.	Delaware
NME Property Holding Co., Inc.	Delaware
NME Psychiatric Hospitals, Inc.	Delaware
NME Rehabilitation Properties, Inc.	Delaware
North Carolina Community Family Medicine, L.L.C.	North Carolina
North Fulton Cardiovascular Medicine, L.L.C.	Georgia
North Fulton Hospitalist Group, L.L.C.	Georgia
North Fulton Medical Center, Inc.	Georgia
North Fulton Primary Care Associates, L.L.C.	Georgia
North Fulton Primary Care - Willeo Rd., L.L.C.	Delaware
North Fulton Primary Care - Windward Parkway, L.L.C.	Georgia
North Fulton Primary Care - Wylie Bridge, L.L.C.	Georgia
North Fulton Pulmonary Specialists, L.L.C.	Georgia
North Fulton Women's Consultants, L.L.C.	Georgia
North Miami Medical Center, Ltd.	Florida
North Shore Medical Billing Center, L.L.C.	Florida
North Shore Medical Center, Inc.	Florida
NUCH of Georgia, L.L.C.	Georgia
NUCH of Massachusetts, LLC	Massachusetts
NUCH of Michigan, Inc.	Michigan
NUCH of Texas	Texas
Okatie Surgical Partners, L.L.C.	South Carolina
Olive Branch Urgent Care #1, LLC	Mississippi
OrNda Hospital Corporation	California
Orthopedic Associates of the Lowcountry, L.L.C.	South Carolina
Paley Institute Global, LLC	Florida
Palm Beach Gardens Community Hospital, Inc.	Florida
Palm Valley Medical Center Campus Association	Arizona
Park Plaza Hospital Billing Center, L.L.C.	Texas
PDN, L.L.C.	Texas
PHPS-CHM Acquisition, Inc.	Delaware
PHPS, Inc.	Arizona
Physician Performance Network, L.L.C.	Delaware
Physician Performance Network of Arizona, LLC	Delaware
Physician Performance Network of Detroit	Michigan
Physician Performance Network of South Carolina, LLC	Delaware
Physician Performance Network of Tucson, LLC	Arizona

Physicians Performance Network of Houston	Texas
Physicians Performance Network of North Texas	Texas
Piedmont Behavioral Medicine Associates, LLC	South Carolina
Piedmont Cardiovascular Physicians, L.L.C.	South Carolina
Piedmont Carolina OB/GYN of York County, L.L.C.	South Carolina
Piedmont Carolina Vascular Surgery, L.L.C.	South Carolina
Piedmont/Carolinas Radiation Therapy, LLC	South Carolina
Piedmont East Urgent Care Center, L.L.C.	South Carolina
Piedmont Express Care at Sutton Road, L.L.C.	South Carolina
Piedmont Family Practice at Baxter Village, L.L.C.	South Carolina
Piedmont Family Practice at Rock Hill, L.L.C.	South Carolina
Piedmont Family Practice at Tega Cay, L.L.C.	South Carolina
Piedmont General Surgery Associates, L.L.C.	South Carolina
Piedmont Internal Medicine at Baxter Village, L.L.C.	South Carolina
Piedmont Physician Network, LLC	South Carolina
Piedmont Pulmonology, L.L.C.	South Carolina
Piedmont Surgical Specialists, L.L.C.	South Carolina
Piedmont Urgent Care and Industrial Health Centers, Inc.	South Carolina
Piedmont Urgent Care Center at Baxter Village, L.L.C.	South Carolina
Placentia-Linda Hospital, Inc.	California
PMC Physician Network, L.L.C.	South Carolina
PM CyFair Land Partners, LLC	Delaware
Practice Partners Management, L.P.	Texas
Premier ACO Physicians Network, LLC	California
Premier Health Plan Services, Inc.	California
Premier Medical Specialists, L.L.C.	Missouri
Professional Liability Insurance Company	Tennessee
Pros Temporary Staffing, Inc.	Illinois
PSS Patient Solution Services, LLC	Texas
Republic Health Corporation of Rockwall County	Nevada
Resolute Health Physicians Network, Inc.	Texas
Resolute Hospital Company, LLC	Delaware
RHC Parkway, Inc.	Delaware
Rheumatology Associates of Atlanta Medical Center, L.L.C.	Georgia
R.H.S.C. El Paso, Inc.	Texas
Rio Grande Valley Indigent Health Care Corporation	Texas
RLC, LLC	Arizona
Rock Bridge Surgical Institute, L.L.C.	Georgia
Saint Francis-Arkansas Physician Network, LLC	Arkansas
Saint Francis-Bartlett Physician Network, LLC	Tennessee
Saint Francis Cardiology Associates, L.L.C.	Tennessee
Saint Francis Cardiovascular Surgery, L.L.C.	Tennessee

Saint Francis Center for Surgical Weight Loss, L.L.C.	Tennessee
Saint Francis Hospital-Bartlett, Inc.	Tennessee
Saint Francis Hospital Billing Center, L.L.C.	Tennessee
Saint Francis Hospital Medicare ACO, LLC	Delaware
Saint Francis Hospital Pro Fee Billing, L.L.C.	Tennessee
Saint Francis Medical Partners, East, L.L.C.	Tennessee
Saint Francis Medical Partners, General Surgery, L.L.C.	Tennessee
Saint Francis Physician Network, LLC	Tennessee
Saint Francis Quality Alliance, LLC	Delaware
Saint Francis Surgical Associates, L.L.C.	Tennessee
Saint Vincent Physician Services, Inc.	Massachusetts
San Ramon Ambulatory Care, LLC	Delaware
San Ramon ASC, L. P.	California
San Ramon Regional Medical Center, LLC	Delaware
San Ramon Surgery Center, L.L.C.	California
SFMP, Inc.	Tennessee
SFMPE - Crittenden, L.L.C.	Arkansas
Shelby Baptist Affinity, LLC	Alabama
Shelby Baptist Ambulatory Surgery Center, LLC	Alabama
Sierra Providence Healthcare Enterprises	Texas
Sierra Providence Health Network, Inc.	Texas
Sierra Vista Hospital, Inc.	California
Sinai-Grace Premier Clinical Management Services LLC	Michigan
SL-HLC, Inc.	Missouri
SLH Physicians, L.L.C.	Missouri
SLH Vista, Inc.	Missouri
SLUH Anesthesia Physicians, L.L.C.	Missouri
SMSJ Imaging Company, LLC	Delaware
SMSJ Tucson Holdings, LLC	Delaware
South Carolina East Cooper Surgical Specialists, L.L.C.	South Carolina
South Carolina Health Services, Inc.	South Carolina
South Carolina SeWee Family Medicine, L.L.C.	South Carolina
South Fulton Health Care Centers, Inc.	Delaware
SouthCare Physicians Group Neurology, L.L.C.	Georgia
SouthCare Physicians Group Obstetrics & Gynecology, L.L.C.	Georgia
Southern Orthopedics and Sports Medicine, L.L.C.	South Carolina
Southern States Physician Operations, Inc.	North Carolina
Southwest Children’s Hospital, LLC	Delaware
Spalding Regional Medical Center, Inc.	Georgia
Spalding Regional OB/GYN, L.L.C.	Georgia
Spalding Regional Physician Services, L.L.C.	Georgia
Springfield Service Holding Corporation	Delaware

SRRMC Management, Inc.	Delaware
St. Christopher’s Pediatric Urgent Care Center - Allentown, L.L.C	Pennsylvania
St. Joseph’s Hospital Surgical Co-Management, LLC	Arizona
St. Mary’s Hospital Cardiovascular Co-Management LLC	Arizona
St. Mary’s Hospital Surgical Co-Management LLC	Arizona
St. Mary’s Levee Company, LLC	Arizona
St. Mary’s Medical Center, Inc.	Florida
Sunrise Medical Group I, L.L.C.	Florida
Sunrise Medical Group II, L.L.C.	Florida
Sunrise Medical Group IV, L.L.C.	Florida
Surgical & Bariatric Associates of Atlanta Medical Center, L.L.C.	Georgia
Surgical Clinical Excellence at Desert Regional, LLC	California
Sutton Road Pediatrics, L.L.C.	South Carolina
Sylvan Grove Hospital, Inc.	Georgia
Tenet Business Services Corporation	Texas
Tenet California, Inc.	Delaware
TenetCare Frisco, Inc.	Texas
Tenet Central Carolina Physicians, Inc.	North Carolina
Tenet EKG, Inc.	Texas
Tenet El Paso, Ltd.	Texas
Tenet Employment, Inc.	Texas
Tenet Finance Corp.	Delaware
Tenet Florida, Inc.	Delaware
Tenet Florida Physician Services II, L.L.C.	Florida
Tenet Florida Physician Services III, L.L.C.	Florida
Tenet Florida Physician Services, L.L.C.	Florida
Tenet Fort Mill, Inc.	South Carolina
Tenet Global Business Center, Inc.	Republic of the Philippines
Tenet HealthSystem Bucks County, L.L.C.	Pennsylvania
Tenet HealthSystem Graduate, L.L.C.	Pennsylvania
Tenet HealthSystem Hahnemann, L.L.C.	Pennsylvania
Tenet HealthSystem Medical, Inc.	Delaware
Tenet HealthSystem Nacogdoches ASC GP, Inc.	Texas
Tenet HealthSystem Philadelphia, Inc.	Pennsylvania
Tenet HealthSystem Roxborough, LLC	Pennsylvania
Tenet HealthSystem St. Christopher’s Hospital for Children, L.L.C.	Pennsylvania
Tenet Hilton Head Heart, L.L.C.	South Carolina
Tenet Hospitals Limited	Texas
Tenet Network Management, Inc.	Florida
Tenet Patient Safety Organization, LLC	Texas
Tenet Physician Resources, LLC	Delaware
Tenet Physician Services - Hilton Head, Inc.	South Carolina

Tenet Rehab Piedmont, Inc.	South Carolina
Tenet Relocation Services, L.L.C.	Texas
Tenet SC East Cooper Hospitalists, L.L.C.	South Carolina
Tenet South Carolina Gastrointestinal Surgical Specialists, L.L.C.	South Carolina
Tenet South Carolina Island Medical, L.L.C.	South Carolina
Tenet South Carolina Lowcountry OB/GYN, L.L.C.	South Carolina
Tenet South Carolina Mt. Pleasant OB/GYN, L.L.C.	South Carolina
Tenet Unifour Urgent Care Center, L.L.C.	North Carolina
Tenet Ventures, Inc.	Delaware
TFPS IV, L.L.C.	Florida
TH Healthcare, Ltd.	Texas
TH International Services Florida, LLC	Florida
TPR Practice Management, LLC	Delaware
TPS VI of PA, L.L.C.	Pennsylvania
TSPE, LLC	Texas
Tucson Hospital Holdings, Inc.	Delaware
Tucson Physician Group Holdings, LLC	Delaware
Turlock Land Company, LLC	California
Twin Cities Community Hospital, Inc.	California
UCC Tucson Holdings, LLC	Delaware
Universal Medical Care Center, L.L.C.	Florida
Urgent Care Centers of Arizona, LLC	Arizona
USPI Holding Company, Inc.[1]	Delaware
Valley Baptist Lab Services, LLC	Texas
Valley Baptist Physician Performance Network	Texas
Valley Baptist Realty Company, LLC	Delaware
Valley Baptist Wellness Center, LLC	Texas
Valley Health Care Network	Texas
Vanguard Health Financial Company, LLC	Delaware
Vanguard Health Holding Company I, LLC	Delaware
Vanguard Health Holding Company II, LLC	Delaware
Vanguard Health Management, Inc.	Delaware
Vanguard Health Systems, Inc.	Delaware
Vanguard Holding Company I, Inc.	Delaware
Vanguard Holding Company II, Inc.	Delaware
Vanguard Medical Specialists, LLC	Delaware
Vanguard Physician Services, LLC	Delaware
VB Brownsville LTACH, LLC	Texas
VBOA ASC GP, LLC	Texas
VBOA ASC Partners, L.L.C.	Texas

[1] Subsidiaries of this entity, in which Tenet Healthcare Corporation directly and indirectly held a 95% ownership interest at December 31, 2020, are set forth in the table below.

VHM Services, Inc.	Massachusetts
VHS Acquisition Corporation	Delaware
VHS Acquisition Partnership Number 1, L.P	Delaware
VHS Acquisition Subsidiary Number 1, Inc.	Delaware
VHS Acquisition Subsidiary Number 3, Inc.	Delaware
VHS Acquisition Subsidiary Number 4, Inc.	Delaware
VHS Acquisition Subsidiary Number 5, Inc.	Delaware
VHS Acquisition Subsidiary Number 6, Inc.	Delaware
VHS Acquisition Subsidiary Number 7, Inc.	Delaware
VHS Acquisition Subsidiary Number 8, Inc.	Delaware
VHS Acquisition Subsidiary Number 9, Inc.	Delaware
VHS Acquisition Subsidiary Number 11, Inc.	Delaware
VHS Acquisition Subsidiary Number 12, Inc.	Delaware
VHS Arizona Heart Institute, Inc.	Delaware
VHS Brownsville Hospital Company, LLC	Delaware
VHS Chicago Market Procurement, LLC	Delaware
VHS Children's Hospital of Michigan, Inc.	Delaware
VHS Detroit Businesses, Inc.	Delaware
VHS Detroit Receiving Hospital, Inc.	Delaware
VHS Detroit Ventures, Inc.	Delaware
VHS Harlingen Hospital Company, LLC	Delaware
VHS Harper-Hutzel Hospital, Inc.	Delaware
VHS Holding Company, Inc.	Delaware
VHS Huron Valley-Sinai Hospital, Inc.	Delaware
VHS Imaging Centers, Inc.	Delaware
VHS New England Holding Company I, Inc.	Delaware
VHS of Anaheim, Inc.	Delaware
VHS of Arrowhead, Inc.	Delaware
VHS of Huntington Beach, Inc.	Delaware
VHS of Illinois, Inc.	Delaware
VHS of Michigan, Inc.	Delaware
VHS of Michigan Staffing, Inc.	Delaware
VHS of Orange County, Inc.	Delaware
VHS of Phoenix, Inc.	Delaware
VHS of South Phoenix, Inc.	Delaware
VHS Outpatient Clinics, Inc.	Delaware
VHS Phoenix Health Plan, Inc.	Delaware
VHS Physicians of Michigan	Michigan
VHS Rehabilitation Institute of Michigan, Inc.	Delaware
VHS San Antonio Partners, LLC	Delaware
VHS Sinai-Grace Hospital, Inc.	Delaware
VHS University Laboratories, Inc.	Delaware

VHS Valley Health System, LLC	Delaware
VHS Valley Holdings, LLC	Delaware
VHS Valley Management Company, Inc.	Delaware
VHS West Suburban Medical Center, Inc.	Delaware
VHS Westlake Hospital, Inc.	Delaware
Walker Baptist Affinity, LLC	Alabama
Watermark Physician Services, Inc.	Illinois
West Boca Health Services, L.L.C.	Florida
West Boca Medical Center, Inc.	Florida
West Boynton Urgent Care, L.L.C.	Florida
West Palm Healthcare Real Estate, Inc.	Florida
West Suburban Radiation Therapy Center, LLC	Delaware
Wilshire Rental Corp.	Delaware

Subsidiaries of USPI Holding Company, Inc.

Name of Entity	State or Other Jurisdiction of Formation
25 East Same Day Surgery, L.L.C.	Illinois
300 PBL Development, LLC	Delaware
45th Street MOB, LLC	Florida
Abrazo Surgical Outpatient Center, LLC	Arizona
Advanced Ambulatory Surgical Care, L.P.	Missouri
Advanced Center for Surgery – Vero Beach, LLC	Florida
Advanced Regional Surgery Center, LLC	Indiana
Advanced Surgery Center of Metairie, LLC	Louisiana
Advanced Surgery Center of Sarasota, LLC	Florida
Advanced Surgery Center of Tampa, LLC	Florida
Advanced Surgical Care of St Louis, LLC	Missouri
Advanced Surgical Concepts, LLC	Louisiana
AdventHealth Surgery Center Celebration, LLC	Florida
AdventHealth Surgery Centers Central Florida, LLC	Florida
AdventHealth Surgery Center Mills Park, LLC	Florida
AdventHealth Surgery Center Wellswood, LLC	Florida
AdventHealth Surgery Centers West Florida, LLC	Florida
AdventHealth Surgery Center Winter Garden, LLC	Florida
Adventist Midwest Health/USP Surgery Centers, L.L.C.	Illinois
AIG Holdings, LLC	Texas
AIGB Global, LLC	Texas
AIGB Group, Inc.	Delaware
AIGB Holdings, Inc.	Delaware
AIGB Management Services, LLC	Texas
Alabama Digestive Health Endoscopy Center, L.L.C.	Alabama
Alamo Heights Surgicare, L.P.	Texas
Alliance Surgery Birmingham, LLC	Delaware
Alliance Surgery, Inc.	Delaware
All Star MOB, LLC	Texas
Ambulatory Surgical Associates, LLC	Tennessee
Ambulatory Surgical Center of Somerville, LLC	New Jersey
The Ambulatory Surgical Center of St. Louis, L.P.	Missouri
American Institute of Gastric Banding Phoenix, Limited Partnership	Arizona
American Institute of Gastric Banding, Ltd.	Texas
Anaheim Hills Medical Imaging, L.L.C.	California
Anesthesia Partners of Gallatin, LLC	Tennessee
APN	Texas
ARC Worcester Center L.P.	Tennessee
Arlington Orthopedic and Spine Hospital, LLC	Texas

Arrowhead Endoscopy and Pain Management Center, LLC	Delaware
ASC of New Jersey LLC	New Jersey
ASC Old Co., LP	Delaware
ASJH Joint Venture, LLC	Arizona
Atlantic Coast Surgical Suites, LLC	New Hampshire
Atlantic Health-USP Surgery Centers, L.L.C.	New Jersey
Avita/USP Surgery Centers, L.L.C.	Ohio
Bagley Holdings, LLC	Ohio
Baptist Plaza Surgicare, L.P.	Tennessee
Baptist Surgery Center, L.P.	Tennessee
Baptist Women's Health Center, LLC	Tennessee
Baptist/USP Surgery Centers, L.L.C.	Texas
Bartlett ASC, LLC	Tennessee
Baylor Surgicare at Baylor Plano, LLC	Texas
Baylor Surgicare at Blue Star, LLC	Texas
Baylor Surgicare at Granbury, LLC	Texas
Baylor Surgicare at Mansfield, LLC	Texas
Baylor Surgicare at North Dallas, LLC	Texas
Baylor Surgicare at Plano Parkway, LLC	Texas
Baylor Surgicare at Plano, LLC	Texas
BBH Imaging Jasper, LLC	Alabama
Bear Creek Surgery Center, LLC	Texas
Beaumont Surgical Affiliates, Ltd.	Texas
Bellaire Outpatient Surgery Center, L.L.P.	Texas
Berkshire Eye, LLC	Pennsylvania
Bloomington ASC, LLC	Indiana
Blue Ridge/USP Surgery Centers, LLC	Tennessee
Bluffton Okatie Surgery Center, L.L.C.	South Carolina
Bon Secours Surgery Center at Harbour View, LLC	Virginia
Bon Secours Surgery Center at Virginia Beach, LLC	Virginia
Bozeman Health/USP Surgery Centers, L.L.C.	Montana
Bozeman MOB, LLC	Montana
Briarcliff Ambulatory Surgery Center, L.P.	Missouri
Bristol Ambulatory Surgery Center, LLC	Tennessee
Brookwood Baptist Health 3, LLC	Delaware
Brookwood Diagnostic Imaging Center, LLC	Delaware
Brookwood Women's Diagnostic Center, LLC	Delaware
California Joint & Spine, LLC	California
Camp Lowell Surgery Center, L.L.C.	Arizona
CareSpot of Austin, LLC	Delaware
CareSpot of Memphis, LLC	Delaware
CareSpot of Orlando/HSI Urgent Care, LLC	Delaware

Carmel Specialty Surgery Center, LLC	Indiana
Carondelet St. Mary's-Northwest, L.L.C.	Arizona
Cascade Spine Center, LLC	Delaware
Castle Rock Surgery Center, LLC	Colorado
Cedar Park Surgery Center, L.L.P.	Texas
Centennial ASC, LLC	Texas
Central California Healthcare Holdings, LLC	Delaware
Central Jersey Surgery Center, LLC	Georgia
Central Virginia Surgi-Center, L.P.	Virginia
Centura Ventures Surgery Centers, LLC	Colorado
Centura/USP Colorado Springs Surgery Centers, L.L.C.	Colorado
Chandler Endoscopy Ambulatory Surgery Center, LLC	Arizona
Charlotte Endoscopic Surgery Center, LLC	Florida
Chattanooga Pain Management Center, LLC	Delaware
Chesterfield Ambulatory Surgery Center, L.P.	Missouri
Chesterfield Anesthesia Associates of Missouri, LLC	Missouri
CHIC/USP Surgery Centers, LLC	Colorado
Chico Surgery Center, L.P.	California
CHRISTUS Cabrini Surgery Center, L.L.C.	Louisiana
Citrus Heights ASC RE, LLC	California
Clarkston ASC Partners, LLC	Michigan
Clarksville Surgery Center, LLC	Tennessee
Coastal Endo LLC	New Jersey
Coast Surgery Center, L.P.	California
Colorado GI Centers, LLC	Colorado
Community Hospital, LLC	Oklahoma
Conroe Surgery Center 2, LLC	Texas
Coral Ridge Outpatient Center, LLC	Florida
Corpus Christi Surgicare, Ltd.	Texas
CreAtiv Management Company, Inc.	Florida
Covenant/USP Surgery Centers, LLC	Tennessee
Creekwood Investors, LLC	Missouri
Creekwood Surgery Center, L.P.	Missouri
Crown Point Surgery Center, LLC	Colorado
CS/USP General Partner, LLC	Texas
CS/USP Surgery Centers, LP	Texas
Dallas Surgical Partners, LLC	Texas
Delray Beach ASC, LLC	Florida
Denton Surgicare Partners, Ltd.	Texas
Denton Surgicare Real Estate, Ltd.	Texas
Denville Surgery Center, LLC	New Jersey
Desert Cove MOB, LLC	Arizona

Desert Ridge Outpatient Surgery, LLC	Arizona
Desoto Surgicare Partners, Ltd.	Texas
Destin ASC RE, LLC	Florida
Destin Surgery Center, LLC	Florida
DeTar/USP Surgery Center, LLC	Texas
DH/USP Sacramento Pain GP, LLC	California
DH/USP SJOSC Investment Company, L.L.C.	Arizona
Dignity/USP Folsom GP, LLC	California
Dignity/USP Grass Valley GP, LLC	California
Dignity/USP Las Vegas Surgery Centers, LLC	Nevada
Dignity/USP Metro Surgery Center, LLC	Arizona
Dignity/USP/John Muir East Bay Surgery Centers, LLC	California
Dignity/USP NorCal Surgery Centers, LLC	California
Dignity/USP Phoenix Surgery Centers II, LLC	Arizona
Dignity/USP Phoenix Surgery Centers, LLC	Arizona
Dignity/USP Redding GP, LLC	California
Dignity/USP Roseville GP, LLC	California
Doctors Outpatient Center for Surgery, LLC	California
Doctors Outpatient Surgery Center of Jupiter, L.L.C.	Florida
East Atlanta Endoscopy Centers, LLC	Georgia
East Portland Surgery Center, LLC	Oregon
East West Surgery Center, L.P.	Georgia
Eastgate Building Center, L.L.C.	Ohio
Effingham Surgical Partners, LLC	Illinois
Einstein Montgomery Surgery Center, LLC	Pennsylvania
Einstein/USP Surgery Centers, L.L.C.	Pennsylvania
El Mirador Surgery Center, L.L.C.	California
El Paso Center for Gastrointestinal Endoscopy, LLC	Texas
El Paso Day Surgery, LLC	Texas
El Paso Urology Surgery Center Curie, LLC	Texas
Emanate/USP Surgery Centers, LLC	California
Emerson Surgery Center, LLC	Missouri
Encinitas Endoscopy Center, LLC	California
Endoscopy Center of Hackensack, LLC	New Jersey
Endoscopy Center of South Sacramento, LLC	California
Endoscopy Consultants, LLC	Georgia
EPIC ASC, LLC	Kansas
Eye Center of Nashville UAP, LLC	Tennessee
Eye Surgery Center of Nashville, LLC	Tennessee
Flatirons Surgery Center, LLC	Colorado
Folsom Outpatient Surgery Center, L.P.	California
Fort Worth Hospital Real Estate, LP	Texas

Fort Worth Surgicare Partners, Ltd.	Texas
Foundation Bariatric Hospital of San Antonio, LLC	Texas
Foundation San Antonio Borrower Sub, LLC	Texas
FPN – Frisco Physicians Network	Texas
Franklin Endo UAP, LLC	Tennessee
Franklin Endoscopy Center, LLC	Tennessee
Fresno Surgery Center, L.P.	California
Frisco Medical Center, L.L.P.	Texas
Frontenac Ambulatory Surgery & Spine Care Center, L.P.	Missouri
FSC Hospital, LLC	Delaware
FSH IT Services, LP	California
Gamma Surgery Center, LLC	Delaware
Garland Surgicare Partners, Ltd.	Texas
GCSA Ambulatory Surgery Center, LLC	Texas
Genesis ASC Partners, LLC	Michigan
Geneva Surgical Suites, LLC	Wisconsin
Georgia Endoscopy Center, LLC	Georgia
Georgia Musculoskeletal Network, Inc.	Georgia
Georgia Spine Surgery Center, LLC	Delaware
Glen Echo Surgery Center, LLC	Maryland
Golden Ridge ASC, LLC	Colorado
Grapevine Surgicare Partners, Ltd.	Texas
Grass Valley Outpatient Surgery Center, L.P.	California
Great Lakes Surgical Suites, LLC	Indiana
Greenville Physicians Surgery Center, LLP	Texas
Greenwood ASC, LLC	Delaware
Hacienda Outpatient Surgery Center, LLC	California
Hagerstown Surgery Center, LLC	Maryland
Harvard Park Surgery Center, LLC	Colorado
Haymarket Surgery Center, LLC	Virginia
Hazelwood Endoscopy Center, LLC	Missouri
HCN Sunnyvale Holdings LLC	Delaware
HCN Surgery Center Holdings, Inc.	Delaware
Healthcare Partners Investments, LLC	Delaware
Health Horizons of Kansas City, Inc.	Tennessee
Health Horizons of Murfreesboro, Inc.	Tennessee
Health Horizons/Piedmont Joint Venture, LLC	Tennessee
Healthmark Partners, Inc.	Delaware
Heritage Park Surgical Hospital, LLC	Texas
Hershey Outpatient Surgery Center, L.P.	Pennsylvania
Hill Country ASC Partners, LLC	Texas
Hill Country Surgery Center, LLC	Texas

Hinsdale Surgical Center, LLC	Illinois
HMA/Solantic Joint Venture, LLC	Delaware
HMHP/USP Surgery Centers, LLC	Ohio
HMH-USP Surgery Centers, LLC	New Jersey
Holston Valley Ambulatory Surgery Center, LLC	Tennessee
Horizon Ridge Surgery Center, LLC	Nevada
Houston PSC, L.P.	Texas
HPI Holdings, LLC	Oklahoma
HPI North, LLC	Oklahoma
HPI Physicians, LLC	Oklahoma
HSS Palm Beach Ambulatory Surgery Center, LLC	Florida
HSS/USP Surgery Center, LLC	Florida
HUMC/USP Surgery Centers, LLC	New Jersey
Hyde Park Surgery Center, LLC	Texas
ICNU Rockford, LLC	Illinois
Integris/USP Health Ventures, LLC	Oklahoma
Irving-Coppell Surgical Hospital, L.L.P.	Texas
Jackson Surgical Center, LLC	New Jersey
Jacksonville Endoscopy Centers, LLC	Florida
JFP UAP Sugarland, LLC	Texas
KHS Ambulatory Surgery Center LLC	New Jersey
KHS/USP Surgery Centers, LLC	New Jersey
Kingsport Ambulatory Surgery Center, LLC	Tennessee
Lake Endoscopy Center, LLC	Florida
Lake Lansing ASC Partners, LLC	Michigan
Lake Surgical Hospital Slidell, LLC	Louisiana
Lakewood Surgery Center, LLC	Delaware
Lancaster Specialty Surgery Center, LLC	Ohio
Lansing ASC Partners, LLC	Michigan
Lawrenceville Surgery Center, L.L.C.	Georgia
Lebanon Endoscopy Center, LLC	Tennessee
Legacy Warren Partners, L.P.	Texas
Legacy/USP Surgery Centers, L.L.C.	Oregon
Leonardtown Surgery Center, LLC	Maryland
Liberty Ambulatory Surgery Center, L.P.	Missouri
Lone Star Endoscopy Center, LLC	Texas
Longleaf Surgery Center, LLC	Florida
Lubbock ASC Holding Co, LLC	Texas
Magnetic Resonance Imaging of San Luis Obispo, Inc.	California
Magnolia Surgery Center Limited Partnership	Delaware
Manchester Ambulatory Surgery Center, LP	Missouri
Maple Lawn Surgery Center, LLC	Maryland

Marion Surgery Center, LLC	Florida
Mary Immaculate Ambulatory Surgery Center, LLC	Virginia
MASC Partners, LLC	Missouri
Mason Ridge Ambulatory Surgery Center, L.P.	Missouri
Mayfield Spine Surgery Center, LLC	Ohio
McLaren ASC of Flint, LLC	Michigan
MCSH Real Estate Investors, Ltd.	Texas
Medical House Staffing, LLC	Texas
Medical Park Tower Surgery Center, LLC	Texas
Medplex Outpatient Surgery Center, Ltd.	Alabama
Memorial Hermann Bay Area Endoscopy Center, LLC	Texas
Memorial Hermann Endoscopy & Surgery Center North Houston, L.L.C.	Texas
Memorial Hermann Endoscopy Center North Freeway, LLC	Texas
Memorial Hermann Specialty Hospital Kingwood, L.L.C.	Texas
Memorial Hermann Sugar Land Surgical Hospital, L.L.P.	Texas
Memorial Hermann Surgery Center Brazoria, LLC	Texas
Memorial Hermann Surgery Center Cypress, LLC	Texas
Memorial Hermann Surgery Center Katy, LLP	Texas
Memorial Hermann Surgery Center Kingsland, L.L.C.	Texas
Memorial Hermann Surgery Center Kirby, LLC	Texas
Memorial Hermann Surgery Center Main Street, LLC	Texas
Memorial Hermann Surgery Center Memorial City, L.L.C.	Texas
Memorial Hermann Surgery Center Northwest LLP	Texas
Memorial Hermann Surgery Center Pinecroft, LLC	Texas
Memorial Hermann Surgery Center Preston Road, Ltd.	Texas
Memorial Hermann Surgery Center Richmond, LLC	Texas
Memorial Hermann Surgery Center Southwest, L.L.P.	Texas
Memorial Hermann Surgery Center Sugar Land, LLP	Texas
Memorial Hermann Surgery Center Texas Medical Center, LLP	Texas
Memorial Hermann Surgery Center – The Woodlands, LLP	Texas
Memorial Hermann Surgery Center Woodlands Parkway, LLC	Texas
Memorial Hermann Texas International Endoscopy Center, LLC	Texas
Memorial Hermann/USP Surgery Centers II, L.P.	Texas
Memorial Hermann/USP Surgery Centers III, LLP	Texas
Memorial Hermann/USP Surgery Centers IV, LLP	Texas
Memorial Hermann West Houston Surgery Center, LLC	Texas
Memorial Surgery Center, LLC	Oklahoma
Merced Ambulatory Surgery Center, LLC	California
Mercy/USP Health Ventures, L.L.C.	Iowa
Metro Specialty Surgery Center, LLC	Indiana
Metro Surgery Center, LLC	Delaware
Metrocrest Surgery Center, L.P.	Texas

Metropolitan New Jersey, LLC	New Jersey
MH Memorial City Surgery, LLC	Texas
MH/USP Bay Area, LLC	Texas
MH/USP Brazoria, LLC	Texas
MH/USP Kingsland, LLC	Texas
MH/USP Kingwood, LLC	Texas
MH/USP Kirby, LLC	Texas
MH/USP Main Street, LLC	Texas
MH/USP North Freeway, LLC	Texas
MH/USP North Houston, LLC	Texas
MH/USP Richmond, LLC	Texas
MH/USP Sugar Land, LLC	Texas
MH/USP TMC Endoscopy, LLC	Texas
MH/USP West Houston, L.L.C.	Texas
MH/USP Woodlands Parkway, LLC	Texas
Michigan ASC Partners, L.L.C.	Michigan
Mid Rivers Ambulatory Surgery Center, L.P.	Missouri
Mid-State Endoscopy Center, LLC	Tennessee
Mid State Endo UAP, LLC	Tennessee
Mid-TSC Development, LP	Texas
Middle Tennessee Ambulatory Surgery Center, L.P.	Delaware
Midland Memorial/USP Surgery Centers, LLC	Texas
Midland Texas Surgical Center, LLC	Texas
Midwest Digestive Health Center, LLC	Missouri
Midwest Specialty Surgery Center, LLC	Indiana
Millennium Surgical Center, LLC	New Jersey
Modesto Radiology Imaging, Inc.	California
Monocacy Surgery Center, LLC	Maryland
Mountain Empire Surgery Center, L.P.	Georgia
MSH Partners, LLC	Texas
MSV Health/USP Surgery Centers, LLC	South Carolina
Munster Specialty Surgery Center, LLC	Indiana
Murdock Ambulatory Surgery Center, LLC	Florida
MVH/USP Surgery Centers, LLC	Pennsylvania
National Imaging Center Holdings, Inc.	Delaware
National Surgery Center Holdings, Inc.	Delaware
Newhope Imaging Center, Inc.	California
New Horizons Surgery Center, LLC	Ohio
New Mexico Orthopaedic Surgery Center, LLC	Georgia
New Salem ASC RE, LLC	Tennessee
NHSC Holdings, LLC	Ohio
NICH GP Holdings, LLC	Delaware

NKCH/USP Briarcliff GP, LLC	Missouri
NKCH/USP Liberty GP, LLC	Missouri
NKCH/USP Surgery Centers II, L.L.C.	Missouri
NKCH/USP Surgery Centers, LLC	Missouri
NMC Surgery Center, L.P.	Texas
North Anaheim Surgery Center, LLC	California
North Atlantic Surgical Suites, LLC	New Hampshire
North Campus Surgery Center, LLC	Missouri
North Central Surgical Center, L.L.P.	Texas
North Denver Musculoskeletal Surgical Partners, LLC	Colorado
North Garland Surgery Center, L.L.P.	Texas
North Haven Surgery Center, LLC	Connecticut
North Shore Same Day Surgery, L.L.C.	Illinois
North Shore Surgical Suites, LLC	Wisconsin
North State Surgery Centers, L.P.	California
Northern Monmouth Regional Surgery Center, L.L.C.	New Jersey
NorthPointe Surgical Suites, LLC	Ohio
Northridge ASC RE, LLC	Tennessee
Northridge Surgery Center, L.P.	Tennessee
NorthShore/USP Surgery Centers II, L.L.C.	Illinois
Northwest Ambulatory Surgery Center, LLC	Oregon
Northwest Georgia Orthopaedic Surgery Center, LLC	Georgia
Northwest Regional ASC, LLC	Delaware
Northwest Regional Surgery Center, LLC	Indiana
Northwest Surgery Center, LLP	Texas
Northwest Surgery Center, Ltd.	Texas
Novant Health/USP Surgery Centers, LLC	North Carolina
Novant/UVA/USP Surgery Centers, LLC	Virginia
NSCH GP Holdings, LLC	Delaware
NSCH/USP Desert Surgery Centers, L.L.C.	Delaware
OCOMS Imaging, LLC	Oklahoma
OCOMS Professional Services, LLC	Oklahoma
Oklahoma Center for Orthopedic and Multi-Specialty Surgery, LLC	Oklahoma
Old Tesson Surgery Center, L.P.	Missouri
Olive Ambulatory Surgery Center, LLC	Missouri
OLOL/USP Surgery Centers, L.L.C.	Texas
Ophthalmology Anesthesia Services, LLC	Florida
Ophthalmology Surgery Center of Orlando, LLC	Florida
Optimum Spine Center, LLC	Georgia
Orlando Health/USP Surgery Centers, L.L.C.	Florida
OrthoArizona Surgery Center Gilbert, LLC	Arizona
OrthoLink ASC Corporation	Tennessee

OrthoLink Physicians Corporation	Delaware
OrthoLink Radiology Services Corporation	Tennessee
OrthoLink/ Georgia ASC, Inc.	Georgia
OrthoLink/Baptist ASC, LLC	Tennessee
OrthoLink/New Mexico ASC, Inc.	Georgia
Orthopedic and Surgical Specialty Company, LLC	Arizona
Orthopedic South Surgical Partners, LLC	Georgia
The Outpatient Center, LLC	Florida
Pacific Endoscopy and Surgery Center, LLC	California
Pacific Endo-Surgical Center, L.P.	California
PAHS/USP Surgery Centers, LLC	Colorado
Pain Diagnostic and Treatment Center, L.P.	California
Palm Beach International Surgery Center, LLC	Florida
Palos Health Surgery Center, LLC	Illinois
Paramus Endoscopy, LLC	New Jersey
Park Cities Surgery Center, LLC	Texas
ParkCreek ASC, LLC	Florida
Parkway Recovery Care Center, LLC	Nevada
Parkway Surgery Center, LLC	Nevada
Parkwest Surgery Center, L.P.	Tennessee
Patient Partners, LLC	Tennessee
Peak Gastroenterology ASC, LLC	Colorado
Pediatric Surgery Center – Odessa, LLC	Florida
Pediatric Surgery Centers, LLC	Florida
PHS/USP Health Ventures, LLC	New Mexico
Physicians Surgery Center at Good Samaritan, LLC	Illinois
Physician’s Surgery Center of Chattanooga, L.L.C.	Tennessee
Physician’s Surgery Center of Knoxville, LLC	Tennessee
Physicians Surgery Center of Tempe, LLC	Oklahoma
Physicians Surgical Center of Ft. Worth, LLP	Texas
Piccard Surgery Center, LLC	Maryland
Piedmont ASC, LLC	North Carolina
Pleasanton Diagnostic Imaging, Inc.	California
Point of Rocks Surgery Center, LLC	Maryland
PPRE, LLC	Texas
Premier Adult and Children’s Surgery Center, LLC	Florida
Premier ASC LLC	New Jersey
Premier Endoscopy ASC, LLC	Arizona
Prince William Ambulatory Surgery Center, LLC	Virginia
Professional Anesthesia Services LLC	Arizona
Providence/UCLA/USP Surgery Centers, LLC	California
Providence/USP Santa Clarita GP, LLC	California

Providence/USP South Bay Surgery Centers, L.L.C.	California
Providence/USP Surgery Centers, L.L.C.	California
Pueblo Ambulatory Surgery Center, LLC	Colorado
RE Plano Med, Inc.	Texas
Reading Ambulatory Surgery Center, L.P.	Pennsylvania
Reading Endoscopy Center, LLC	Delaware
Reagan Street Surgery Center, LLC	California
Redmond Surgery Center, LLC	Tennessee
Renaissance Surgery Center, LLC	California
Resurgens East Surgery Center, LLC	Georgia
Resurgens Fayette Surgery Center, LLC	Georgia
Resurgens Surgery Center, LLC	Georgia
Richmond ASC Leasing Company, LLC	Virginia
River North Same Day Surgery, L.L.C.	Illinois
Riverside Ambulatory Surgery Center, LLC	Missouri
Rock Hill Surgery Center, LLC	South Carolina
Rockwall Ambulatory Surgery Center, L.L.P.	Texas
Rocky Mountain Endoscopy Centers, LLC	Colorado
Roseville Surgery Center, L.P.	California
Roswell Surgery Center, L.L.C.	Georgia
Sacramento Midtown Endoscopy Center, LLC	California
Safety Harbor ASC Company, LLC	Florida
Saint Agnes/Dignity/USP Surgery Centers, LLC	California
Saint Agnes/USP Surgery Centers, LLC	California
Saint Francis Surgery Center, L.L.C.	Tennessee
Saint Thomas Campus Surgicare, L.P.	Tennessee
Saint Thomas Surgery Center New Salem, LLC	Tennessee
Saint Thomas/USP – Baptist Plaza, L.L.C.	Tennessee
Saint Thomas/USP Surgery Centers II, L.L.C.	Tennessee
Saint Thomas/USP Surgery Centers, L.L.C.	Tennessee
Salmon Surgery Center, LLC	Washington
Same Day Management, L.L.C.	Illinois
Same Day SC of Central NJ, LLC	New Jersey
Same Day Surgery, L.L.C.	Illinois
San Antonio Endoscopy, L.P.	Texas
San Fernando Valley Surgery Center, L.P.	California
San Gabriel Valley Surgical Center, L.P.	California
San Martin Surgery Center, LLC	Nevada
San Ramon Network Joint Venture, LLC	Delaware
Santa Barbara Outpatient Surgery Center, LLC	California
Santa Clarita Surgery Center, L.P.	California
Savannah Endoscopy Ambulatory Surgery Center, LLC	Georgia

Schertz Surgery Center, LLC	Texas
Scripps Encinitas Surgery Center, LLC	California
Scripps/USP Surgery Centers, L.L.C.	California
SCNRE, LLC	Texas
Seaside Surgery Center, LLC	Florida
Shands/Solantic Joint Venture, LLC	Delaware
Shore Outpatient Surgicenter, L.L.C.	Georgia
Shoreline Real Estate Partnership, LLP	Texas
Shoreline Surgery Center, LLP	Texas
Shrewsbury Surgery Center, LLC	New Jersey
Sierra Pacific Surgery Center, LLC	Tennessee
Silicon Valley Outpatient Surgery Centers, LLC	California
Silver Cross Ambulatory Surgery Center, LLC	Illinois
Silver Cross/USP Surgery Centers, LLC	Illinois
Siouxland Surgery Center Limited Liability Partnership	Iowa
SLPA ACO, LLC	Missouri
Solantic Corporation	Delaware
Solantic Development, LLC	Delaware
Solantic Holdings Corporation	Delaware
Solantic of Jacksonville, LLC	Delaware
Solantic of Orlando, LLC	Delaware
Solantic/South Florida, LLC	Delaware
South County Outpatient Endoscopy Services, L.P.	Missouri
South Denver Musculoskeletal Surgical Partners, LLC	Colorado
South Florida Ambulatory Surgical Center, LLC	Florida
Southeast Ohio Surgical Suites, LLC	Ohio
The Southeastern Spine Institute Ambulatory Surgery Center, L.L.C.	South Carolina
Southwest Ambulatory Surgery Center, L.L.C.	Oklahoma
Southwest Endoscopy, LLC	Arizona
Southwest Orthopedic and Spine Hospital Real Estate, LLC	Delaware
Southwest Orthopedic and Spine Hospital, LLC	Arizona
Southwestern Ambulatory Surgery Center, LLC	Pennsylvania
SPC at the Star, LLC	Texas
Specialty Surgery Center of Fort Worth, L.P.	Texas
Specialty Surgicenters, Inc.	Georgia
Spinal Diagnostics and Treatment Centers, L.L.C.	California
Spine & Joint Physician Associates	Texas
SSI Holdings, Inc.	Georgia
St. Augustine Endoscopy Center, LLC	Florida
St. Joseph’s Outpatient Surgery Center, LLC	Arizona
St. Joseph’s Surgery Center, L.P.	California
St. Louis Physician Alliance, LLC	Missouri

St. Louis Surgical Center, LLC	Missouri
St. Louis Urology Center, LLC	Missouri
St. Luke's/USP Surgery Centers, LLC	Missouri
St. Mary's Ambulatory Surgery Center, LLC	Virginia
St. Vincent Health/USP, LLC	Indiana
St. Vincent/USP Surgery Centers, LLC	Arkansas
Stockton Outpatient Surgery Center, LLC	California
Suburban Endoscopy Center, LLC	New Jersey
Summit View Surgery Center, LLC	Colorado
Sun View Imaging, L.L.C.	New Mexico
SurgCenter at Paradise Valley, LLC	Arizona
SurgCenter Camelback, LLC	Arizona
SurgCenter Northeast, LLC	Florida
SurgCenter of Deer Valley, LLC	Arizona
SurgCenter of Glen Burnie, LLC	Maryland
SurgCenter of Palm Beach Gardens, LLC	Florida
SurgCenter of Plano, LLC	Texas
SurgCenter of Southern Maryland, LLC	Maryland
SurgCenter of St. Lucie, LLC	Florida
SurgCenter of White Marsh, LLC	Maryland
SurgCenter Pinellas, LLC	Florida
SurgCenter Tucson, LLC	Arizona
Surgery Affiliate of El Paso, LLC	Texas
The Surgery Center at Jensen Beach, LLC	Florida
Surgery Center at Mount Pleasant, LLC	South Carolina
Surgery Center at University Park, LLC	Florida
The Surgery Center at Williamson, LLC	Texas
Surgery Center of Atlanta, LLC	Georgia
Surgery Center of Canfield, LLC	Ohio
Surgery Center of Columbia, L.P.	Missouri
Surgery Center of Coral Gables, LLC	Florida
Surgery Center of Okeechobee, LLC	Florida
Surgery Center of Pembroke Pines, L.L.C.	Florida
Surgery Center of Peoria, L.L.C.	Oklahoma
Surgery Center of Richardson Physician Partnership, L.P.	Texas
Surgery Center of Santa Barbara, LLC	California
Surgery Center of Scottsdale, LLC	Oklahoma
Surgery Center of Tempe Real Estate, L.L.C.	Arizona
Surgery Center of Tempe Real Estate II, L.L.C.	Arizona
Surgery Centers of America II, L.L.C.	Oklahoma
Surgery Centre of SW Florida, LLC	Florida
Surgical Elite of Avondale, L.L.C.	Arizona

Surgical Health Partners, LLC	Tennessee
Surgical Institute Management, LLC	Pennsylvania
Surgical Institute of Reading, LLC	Pennsylvania
Surgical Specialists at Princeton, LLC	New Jersey
Surgicare of Miramar, L.L.C.	Florida
Surginet, Inc.	Tennessee
Surgis Management Services, Inc.	Tennessee
Surgis of Chico, Inc.	Tennessee
Surgis of Phoenix, Inc.	Tennessee
Surgis of Redding, Inc.	Tennessee
Surgis of Victoria, Inc.	Tennessee
Surgis, Inc.	Delaware
Tamarac Surgery Center, LLC	Florida
Tempe New Day Surgery Center, LP	Arizona
Templeton Imaging, Inc.	California
TENN SM, LLC	Tennessee
Terre Haute Surgical Center, LLC	Indiana
Teton Outpatient Services, LLC	Wyoming
Texan Ambulatory Surgery Center, L.P.	Texas
Texas Endoscopy Centers, LLC	Texas
Texas Health Venture Arlington Hospital, LLC	Texas
Texas Health Venture Baylor Plano, LLC	Texas
Texas Health Venture Carrollton, LLC	Texas
Texas Health Venture Centennial, LLC	Texas
Texas Health Venture Ennis, LLC	Texas
Texas Health Venture Fort Worth, L.L.C.	Texas
Texas Health Venture Granbury, LLC	Texas
Texas Health Venture Heritage Park, LLC	Texas
Texas Health Venture Keller, LLC	Texas
Texas Health Venture Las Colinas, LLC	Texas
Texas Health Venture Mansfield, LLC	Texas
Texas Health Venture Plano Endo, LLC	Texas
Texas Health Venture Plano Parkway, LLC	Texas
Texas Health Venture Plano, LLC	Texas
Texas Health Venture Texas Spine, LLC	Texas
Texas Health Ventures Group L.L.C.	Texas
Texas Orthopedics Surgery Center, LLC	Texas
Texas Regional Medical Center, LLC	Texas
Texas Spine and Joint Hospital, LLC	Texas
Theda Oaks Gastroenterology & Endoscopy Center, LLC	Texas
THV Park Cities, LLC	Texas
THVG Arlington GP, LLC	Delaware

THVG Bariatric GP, LLC	Texas
THVG Bariatric, L.L.C.	Texas
THVG Bedford GP, LLC	Delaware
THVG Bellaire GP, LLC	Delaware
THVG Denton GP, LLC	Delaware
THVG DeSoto GP, LLC	Delaware
THVG DSP GP, LLC	Delaware
THVG Fort Worth GP, LLC	Delaware
THVG Frisco GP, LLC	Delaware
THVG Garland GP, LLC	Delaware
THVG Grapevine GP, LLC	Delaware
THVG Irving-Coppell GP, LLC	Delaware
THVG Lewisville GP, LLC	Delaware
THVG North Garland GP, LLC	Delaware
THVG Park Cities/Trophy Club GP, LLC	Delaware
THVG Rockwall 2 GP, LLC	Texas
THVG Valley View GP, LLC	Delaware
Titan Health Corporation	Delaware
Titan Health of Chattanooga, Inc.	California
Titan Health of Hershey, Inc.	California
Titan Health of Mount Laurel, LLC	California
Titan Health of North Haven, Inc.	California
Titan Health of Pittsburgh, Inc.	California
Titan Health of Pleasant Hills, Inc.	California
Titan Health of Princeton, Inc.	California
Titan Health of Sacramento, Inc.	California
Titan Health of Saginaw, Inc.	California
Titan Health of Titusville, Inc.	California
Titan Health of West Penn, Inc.	California
Titan Health of Westminster, Inc.	California
Titan Management Corporation	California
Titusville Center for Surgical Excellence, LLC	Delaware
TLC ASC, LLC	Florida
TMC Holding Company, LLC	Texas
Toms River Surgery Center, L.L.C.	New Jersey
TOPS Specialty Hospital, Ltd.	Texas
Total Joint Center of the Northland, LLC	Missouri
Tower Road Real Estate, LLC	Texas
Tower/USP Surgery Centers, LLC	Pennsylvania
TPG Hospital, LLC	Oklahoma
Treasure Coast ASC, LLC	Florida
The Tresanti Surgical Center, LLC	California

TRMC Holdings, LLC	Texas
Trophy Club Medical Center, L.P.	Texas
True Medical Weight Loss, L.P.	Texas
True Medical Wellness, LP	Texas
True Results Georgia, Inc.	Georgia
True Results HoldCo, LLC	Delaware
True Results Missouri, LLC	Missouri
Tucson Digestive Institute, LLC	Arizona
Turlock Imaging Services, LLC	California
Tuscan Surgery Center at Las Colinas, LLC	Texas
Twin Cities Ambulatory Surgery Center, L.P.	Missouri
UAP Las Colinas Endo, LLC	Texas
UAP Lebanon Endo, LLC	Tennessee
UAP Nashville Endoscopy, LLC	Tennessee
UAP of Arizona, Inc.	Arizona
UAP of California, Inc.	California
UAP of Missouri, Inc.	Missouri
UAP of New Jersey, Inc.	New Jersey
UAP of Oklahoma, Inc.	Oklahoma
UAP of Tennessee, Inc.	Tennessee
UAP of Texas, Inc.	Texas
UAP Scopes, LLC	Missouri
Ulysses True Results NewCo, LLC	Delaware
UMC Surgery Center Lubbock, LLC	Texas
UMC-USP Surgery Centers, LLC	Texas
Underwood Surgery Center, LLC	Florida
United Anesthesia Partners, Inc.	Delaware
United Real Estate Development, Inc.	Texas
United Real Estate Holdings, Inc.	Texas
United Surgical Partners Holdings, Inc.	Delaware
United Surgical Partners International, Inc.	Delaware
University Surgery Center, Ltd.	Florida
University Surgical Partners of Dallas, L.L.P.	Texas
Upper Bay Surgery Center, LLC	Maryland
Upper Cumberland Physicians' Surgery Center, LLC	Tennessee
USP 12th Ave Real Estate, Inc.	Texas
USP Acquisition Corporation	Delaware
USP Alexandria, Inc.	Louisiana
USP Assurance Company	Vermont
USP Athens, Inc.	Georgia
USP Atlanta, Inc.	Georgia
USP Austin, Inc.	Texas

USP Bariatric, LLC	Delaware
USP Beaumont, Inc.	Texas
USP Bergen, Inc.	New Jersey
USP Bloomington, Inc.	Indiana
USP Bridgeton, Inc.	Missouri
USP/Carondelet Tucson Surgery Centers, LLC	Arizona
USP Cedar Park, Inc.	Texas
USP Chesterfield, Inc.	Missouri
USP Chicago, Inc.	Illinois
USP Cincinnati, Inc.	Ohio
USP Coast, Inc.	California
USP Columbia, Inc.	Missouri
USP Connecticut, Inc.	Connecticut
USP Corpus Christi, Inc.	Texas
USP Creve Coeur, Inc.	Missouri
USP Denver, Inc.	Colorado
USP Des Peres, Inc.	Missouri
USP Destin, Inc.	Florida
USP Domestic Holdings, Inc.	Delaware
USP Effingham, Inc.	Illinois
USP Encinitas Endoscopy, Inc.	California
USP Fenton, Inc.	Missouri
USP Festus, Inc.	Missouri
USP Florissant, Inc.	Missouri
USP Fort Lauderdale, Inc.	Florida
USP Fort Worth Hospital Real Estate, Inc.	Texas
USP Fredericksburg, Inc.	Virginia
USP Fresno, Inc.	California
USP Frontenac, Inc.	Missouri
USP Gateway, Inc.	Missouri
USP Harbour View, Inc.	Virginia
USP-HMH Surgery Center at Central Jersey, LLC	New Jersey
USP HMH Surgery Center at Shore, LLC	New Jersey
USP Houston, Inc.	Texas
USP Indiana, Inc.	Indiana
USP International Holdings, Inc.	Delaware
USP Jersey City, Inc.	New Jersey
USP Kansas City, Inc.	Missouri
USP Knoxville, Inc.	Tennessee
USP Little Rock, Inc.	Arkansas
USP Long Island, Inc.	Delaware
USP Louisiana, Inc.	Louisiana

USP Lubbock, Inc.	Texas
USP Maryland, Inc.	Maryland
USP Mason Ridge, Inc.	Missouri
USP Mattis, Inc.	Missouri
USP Michigan, Inc.	Michigan
USP Midland Real Estate, Inc.	Texas
USP Midland, Inc.	Texas
USP Midwest, Inc.	Illinois
USP Mission Hills, Inc.	California
USP Montana, Inc.	Montana
USP Morris, Inc.	New Jersey
USP Mt. Vernon, Inc.	Illinois
USP Nevada Holdings, LLC	Nevada
USP Nevada, Inc.	Nevada
USP New Hampshire, Inc.	New Hampshire
USP New Jersey, Inc.	New Jersey
USP Newport News, Inc.	Virginia
USP North Carolina, Inc.	North Carolina
USP North Kansas City, Inc.	Missouri
USP North Texas, Inc.	Delaware
USP Northwest Arkansas, Inc.	Arkansas
USP Office Parkway, Inc.	Missouri
USP Ohio RE, Inc.	Ohio
USP OKC, Inc.	Oklahoma
USP OKC Manager, Inc.	Oklahoma
USP Oklahoma, Inc.	Oklahoma
USP Olive, Inc.	Missouri
USP Orlando, Inc.	Florida
USP Philadelphia, Inc.	Pennsylvania
USP Phoenix, Inc.	Arizona
USP Portland, Inc.	Oregon
USP Reading, Inc.	Pennsylvania
USP Richmond II, Inc.	Virginia
USP Richmond, Inc.	Virginia
USP Sacramento, Inc.	California
USP San Antonio, Inc.	Texas
USP Santa Barbara Surgery Centers, Inc.	California
USP Securities Corporation	Tennessee
USP Silver Cross, Inc.	Illinois
USP Siouxland, Inc.	Iowa
USP Somerset, Inc.	New Jersey
USP South Carolina, Inc.	Delaware

USP Southlake RE, Inc.	Texas
USP/SOS Joint Venture, LLC	Oklahoma
USP St. Louis, Inc.	Missouri
USP St. Louis Urology, Inc.	Missouri
USP St. Peters, Inc.	Missouri
USP Sunset Hills, Inc.	Missouri
USP Tennessee, Inc.	Tennessee
USP Texas Air, L.L.C.	Texas
USP Texas, L.P.	Texas
USP TJ STL, Inc.	Missouri
USP Torrance, Inc.	California
USP Tucson, Inc.	Arizona
USP Turnersville, Inc.	New Jersey
USP Virginia Beach, Inc.	Virginia
USP Washington, Inc.	Washington
USP Waxahachie Management, L.L.C.	Texas
USP Webster Groves, Inc.	Missouri
USP West Covina, Inc.	California
USP Westwood, Inc.	California
USP Winter Park, Inc.	Florida
USP Wisconsin, Inc.	Wisconsin
USPI Group Holdings, Inc.	Delaware
USPI Holdings, Inc.	Delaware
USPI Physician Strategy Group, LLC	Texas
USPI San Diego, Inc.	California
USPI Stockton, Inc.	California
USPI Surgical Services, Inc.	Delaware
Utica ASC Partners, LLC	Michigan
Utica/USP Tulsa, L.L.C.	Oklahoma
Vanguard ASC LLC	New Jersey
Ventana Surgical Center, LLC	California
Veroscan, Inc.	Delaware
VHS San Antonio Imaging Partners, L.P.	Delaware
Victoria Ambulatory Surgery Center, L.P.	Delaware
Virtua-USP Princeton, LLC	New Jersey
Walker Street Imaging Care, Inc.	California
Warner Park Surgery Center, LLC	Arizona
Webster Ambulatory Surgery Center, L.P.	Missouri
Wellington Endo, LLC	Florida
Wellstar/USP Joint Venture I, LLC	Georgia
Wellstar/USP Joint Venture II, LLC	Georgia
West Bozeman Surgery Center, LLC	Montana

Westgate Surgery Center, LLC	Arizona
Westlake Hospital, LLC	Texas
Westlawn Surgery Center, LLC	Tennessee
Westminster Surgery Center, LLC	Maryland
Westminster Surgery Centers, LLC	Colorado
WHASA, L.C.	Texas
White Fence Surgical Suites, LLC	Ohio
Willamette Spine Center Ambulatory Surgery, LLC	Delaware
Wilmington Endoscopy Center, LLC	North Carolina
Winter Haven Ambulatory Surgical Center, L.L.C.	Florida
Wisconsin Specialty Surgery Center, LLC	Wisconsin
Wymark Surgery Center, LLC	California
YNHHSC/USP Surgery Centers, LLC	Connecticut

Exhibit 23(a)

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement Nos. 033-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482, 333-74216, 333-151884, 333-151887, 333-166767, 333-166768, 333-191614, 333-196262, 333-212844, 333-212846, and 333-231515 on Form S-8 of our reports dated February 19, 2021, relating to the consolidated financial statements and financial statement schedule of Tenet Healthcare Corporation and subsidiaries, and the effectiveness of Tenet Healthcare Corporation and subsidiaries' internal control over financial reporting, appearing in this Annual Report on Form 10-K of Tenet Healthcare Corporation for the year ended December 31, 2020.

/s/ Deloitte & Touche LLP
Dallas, Texas
February 19, 2021

Exhibit 23(b)

CONSENT OF INDEPENDENT ACCOUNTANTS

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 033-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482, 333-74216, 333-151884, 333-151887, 333-166767, 333-166768, 333-191614, 333-196262, 333-212844, 333-212846 and 333-231515) of Tenet Healthcare Corporation of our report dated November 1, 2020 relating to the financial statements of Texas Health Ventures Group L.L.C., and its subsidiaries, which appears in this Annual Report on Form 10-K of Tenet Healthcare Corporation.

/s/ PricewaterhouseCoopers LLP
Dallas, Texas
February 19, 2021

Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Ronald A. Rittenmeyer, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 19, 2021

/s/ RONALD A. RITTENMEYER

Ronald A. Rittenmeyer

Executive Chairman and Chief Executive Officer

Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 19, 2021

/s/ DANIEL J. CANCELMI

Daniel J. Cancelmi

Executive Vice President and Chief Financial Officer

Exhibit 32

Certifications Pursuant to Section 1350 of Chapter 63
of Title 18 of the United States Code

We, the undersigned Ronald A. Rittenmeyer and Daniel J. Cancelmi, being, respectively, the Executive Chairman and Chief Executive Officer and the Executive Vice President and Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Annual Report on Form 10-K for the year ended December 31, 2020 (the "Form 10-K"), to be filed with the Securities and Exchange Commission on the date hereof, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and (ii) the information contained in the Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: February 19, 2021 /s/ RONALD A. RITTENMEYER

Ronald A. Rittenmeyer

Executive Chairman and Chief Executive Officer

Date: February 19, 2021 /s/ DANIEL J. CANCELMI

Daniel J. Cancelmi

Executive Vice President and Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.