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, 2021

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, 2021, 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 $5.4 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 31, 2022, there were 107,416,704 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2022 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

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PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company headquartered in Dallas, Texas. Through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI"), at December 31, 2021, we operated an expansive care network that included 60 hospitals and 535 other healthcare facilities, including surgical hospitals, ambulatory surgery centers ("ASCs"), imaging centers, off-campus emergency departments and micro-hospitals. We also had over 20 ASCs in development at December 31, 2021. In addition, we operate Conifer Health Solutions, LLC through our Conifer Holdings, Inc. subsidiary ("Conifer"), which provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients. 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 operating 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 2021, the ongoing COVID-19 pandemic significantly impacted, and it continues to affect, all three segments of our business, as well as our patients, communities and employees. As a provider of healthcare services, we are acutely affected by the public health and economic effects of the pandemic. Throughout MD&A, we have provided additional information on the impact of the COVID-19 pandemic on our results of operations, disclosed certain of the steps we have taken, and are continuing to take, in response, and described various legislative actions that have mitigated some of the economic disruption caused by the pandemic on our business. The ultimate extent and scope of the pandemic and its future impact on our business remain unknown. For information about risks and uncertainties related to COVID-19 that could affect our business, financial condition, results of operations and cash flows, we refer you to the Risk Factors section below.

OPERATIONS

HOSPITAL OPERATIONS SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—In 2021, we continued to make investments across our Hospital Operations segment to offer more convenient access to higher-demand and higher-acuity clinical service lines in the communities we serve. We also exited service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. In April 2021, we divested the majority of our urgent care centers and, in August 2021, we sold five Miami-area hospitals and certain related operations.

At December 31, 2021, our subsidiaries operated 60 hospitals, serving primarily urban and suburban communities in nine states. Our subsidiaries had sole ownership of 52 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 112 outpatient centers at December 31, 2021, the majority of which are provider-based and freestanding imaging centers, off-campus hospital emergency departments, provider-based ASCs and micro-hospitals. In addition, at December 31, 2021, 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 750 physician practices; several accountable care organizations and 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 is accredited by The Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and Conditions for Coverage and are eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs.

The following table lists, by state, the hospitals wholly owned, operated as part of a joint venture, or leased and operated by our wholly owned subsidiaries at December 31, 2021:

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)	Nogales	25	Owned
St. Joseph's Hospital	Tucson	486	Owned
St. Mary's Hospital	Tucson	400	Owned
California			
Desert Regional Medical Center(5)	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital and Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center(6)	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	172	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center(7)	San Ramon	123	JV/Owned
Tenet Health Central Coast Sierra Vista Regional Medical Center	San Luis Obispo	162	Owned
Tenet Health Central Coast Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Delray Medical Center	Delray Beach	536	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Palm Beach Gardens Medical Center	Palm Beach Gardens	199	Owned
St. Mary's Medical Center	West Palm Beach	460	Owned
West Boca Medical Center	Boca Raton	195	Owned
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	126	Owned
MetroWest Medical Center – Leonard Morse Campus(3)	Natick	103	Owned
Saint Vincent Hospital	Worcester	290	Owned

Hospital	Location	Licensed Beds	Status
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	300	Owned
Tennessee			
Saint Francis Hospital	Memphis	479	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	607	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	110	Owned
Nacogdoches Medical Center	Nacogdoches	161	Owned
North Central Baptist Hospital	San Antonio	443	Owned
Northeast Baptist Hospital	San Antonio	347	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		**15,379**	

(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, 2021, 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) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital.
(5) Lease expires in May 2027.
(6) Lease expires in July 2045.
(7) Owned by a limited liability company formed as part of a joint venture with John Muir Health ("JMH"), a not-for-profit health system in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the entity at December 31, 2021, and JMH owned a 49% interest.

Information regarding the utilization of licensed beds and other operating statistics at December 31, 2021 and 2020 can be found in MD&A.

At December 31, 2021, our Hospital Operations segment also included 43 imaging centers, 14 off-campus emergency departments and 10 ASCs operated as departments of our hospitals and under the same license, as well as 45 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of 26 imaging centers, 15 emergency facilities (14 of which are licensed as micro-hospitals), two ASCs and two urgent care centers. Approximately half of the outpatient centers in our Hospital Operations segment at December 31, 2021 were in Texas and California, 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, competitive 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 four clinically integrated networks ("CINs") – in Alabama, Arizona, California, Massachusetts 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.

AMBULATORY CARE SEGMENT

Our Ambulatory Care segment is comprised of USPI's ambulatory surgery centers and surgical hospitals. At December 31, 2021, we owned approximately 95% of USPI, and Baylor University Medical Center ("Baylor") owned approximately 5%. We continue to focus on opportunities to expand our Ambulatory Care segment through acquisitions, organic growth, construction of new outpatient centers and strategic partnerships. In December 2021, in connection with the closing of a previously announced transaction with Surgical Center Development #3, LLC and Surgical Center Development #4, LLC ("SCD"), subsidiaries of USPI acquired SCD's ownership interests in 86 musculoskeletal-focused ASCs, along with other related ambulatory support services. In an effort to attain a majority ownership position in certain of the ASCs to consolidate their financial results, USPI has separately made offers, and continues to make offers in an ongoing process, to acquire a portion of the equity interests from the physician owners; USPI acquired such equity interests in 10 centers prior to the end of 2021. At December 31, 2021, USPI had interests in a total of 399 ASCs and 24 surgical hospitals in 34 states.

Also as previously announced, USPI and SCD's principals have entered into a joint venture and development agreement under which USPI will have the exclusive option to partner with affiliates of SCD on the future development of a minimum target of 50 de novo ASCs over a period of five years. We believe that these transactions will enable us to continue to sharpen our focus on the growth and expansion of ambulatory surgical services.

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 does not currently have management services contracts for the SCD facilities acquired in December 2021 in which it owns only a minority interest.

We believe USPI's ASCs 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 times between cases than they could expect in an acute care hospital setting. In addition, we believe many physicians choose to perform surgery in USPI's facilities because their patients prefer the comfort of a less institutional atmosphere and the expediency of simplified registration and discharge procedures. 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 growth in outpatient surgery. Improved anesthesia has shortened recovery time by minimizing post-operative side effects, such as nausea and drowsiness, thereby preventing the need for overnight hospitalization in many cases. In addition, certain complex surgeries, previously performed only in an inpatient setting, are now capable of being performed in a surgery center.

In addition to these technological and 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, self-funded employers continue to shift additional financial responsibility to patients through higher co-pays, deductibles and premium contributions to curb annual increases in their employee health benefits costs. 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 over time. 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, 2021, 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 potential 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 comprehensive amendment to and restatement of the master 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. If consummated, the spin-off is expected to potentially enhance shareholder value and, to a lesser degree, reduce the level of our debt through a tax-free debt-for-debt exchange. There can be no assurance regarding the timeframe for completion of the Conifer 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 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 CINs 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, 2021, Conifer provided one or more of the business process services described above to approximately 650 Tenet and non-Tenet hospital and other clients nationwide. Tenet and CHI facilities represented approximately 45% of these clients, and the remainder were unaffiliated health systems, hospitals, physician practices, self-insured organizations, health plans and other entities. In 2012, we entered into an agreement documenting the terms and conditions of various services Conifer provides to Tenet hospitals ("RCM Agreement"), as well as an agreement documenting certain administrative services our Hospital Operations segment provides to Conifer. In March 2021, we entered into a month-to-month agreement amending the RCM Agreement effective January 1, 2021 ("Amended RCM Agreement") to update certain terms and conditions related to the revenue cycle management services Conifer provides to Tenet hospitals. We believe the pricing terms for the services provided under the Amended RCM Agreement are commercially reasonable and consistent with estimated third-party terms. As noted above, 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 on December 31, 2032. For the year ended December 31, 2021, approximately 38% of Conifer's net operating revenues were attributable to its relationship with Tenet and 45% were attributable to its relationship with CHI. 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 spin-off plans for Conifer may have an adverse impact on our ability to secure new clients for Conifer.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2021 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. In addition, we maintain administrative offices in regions 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 large part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who are members of 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, 2021, we owned over 750 physician practices, and our subsidiaries employed (where permitted by state law) or otherwise affiliated with over 1,500 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 2021, we continued to experience challenges in recruiting and retaining physicians as a result of the prioritization of COVID-19 care and the challenges associated with relocating physicians during the pandemic. In some of our markets, physician recruitment and retention are affected by a shortage of qualified physicians in certain higher-demand clinical service lines and specialties. 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, 2021, our subsidiaries and affiliates employed approximately 101,100 people (of which approximately 24% were part-time employees) in our three operating segments, as follows:

Hospital Operations	70,000
Ambulatory Care	20,200
Conifer	10,900
Total	**101,100**

At December 31, 2021, our employee headcount had decreased by nearly 9,000 employees as compared to December 31, 2020, primarily due to the divestiture of five hospitals in Florida and our urgent care business in 2021. At December 31, 2021, we had employees in all 50 U.S. states and the District of Columbia, as well as over 2,000 employees providing support across our entire network at our Global Business Center in the Philippines. Approximately 31% of our employees are nurses.

Board Oversight—Our board of directors and its committees oversee human capital matters through regular reports from management and advisors. The board's human resources committee ("HR Committee") is responsible for establishing general compensation policies that (1) support our overall business strategies and objectives, (2) enhance our efforts to attract and retain skilled employees, (3) link compensation with our business objectives and organizational performance, and (4) provide competitive compensation opportunities for key executives. The HR Committee also provides, among other things, its perspectives regarding performance management, succession planning, leadership development, diversity, recruiting, retention and employee training. The board's environmental, social and governance ("ESG") committee, which was formed in 2021, provides oversight with respect to our ESG strategy and guidance on ESG matters, including human rights, diversity and inclusion, and other ESG issues that are relevant to our business.

Human Resources Practices—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.

Compensation and Benefits; Culture—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:

- a competitive range of compensation and benefit programs designed to reward performance and promote well-being;
- opportunities for continuing education and advancement through a broad range of clinical training and leadership development experiences, including in-person and online courses and mentoring opportunities;
- a supportive, inclusive and patient-centered culture based on respect for others;
- company-sponsored efforts encouraging and recognizing volunteerism and community service; and
- a code of conduct that promotes integrity, accountability and transparency, among other high ethical standards.

Employee Safety and Welfare—We believe our employees comprise a community built on care, and we place a high priority on maintaining a secure and healthy workplace for them. We promote a culture of safety and reporting by connecting

employee safety policies with patient safety policies, and we review and refine the policies regularly. At our hospitals, outpatient facilities, and other care sites and clinics, we align staffing to need in our nursing units, and we invest in appropriate training to improve the competency of our caregivers. With the onset of the pandemic, we instituted COVID-safe infrastructure and heightened our infection-prevention protocols. We maintain consistent availability of personal protective equipment and disinfection supplies, and we regularly provide concise and current infection prevention guidance.

We also offer resources to help employees manage challenging circumstances, including a comprehensive employee assistance program comprised of counseling services, financial guidance and legal aid. The Tenet Care Fund (the "Care Fund") is a 501(c)(3) public charity that provides financial assistance to our employees who have experienced hardship due to, among other things, natural disasters, extended illness or injury, and the impact of the COVID-19 pandemic. The Care Fund is funded primarily by our employees for our employees.

Diversity and Inclusion—We 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, 2021, our total workforce was greater than 75% female, and nearly 50% of our employees self-identified as racially or ethnically diverse. Over 55% of new employees (i.e., those we hired in 2021) self-identified as racially or ethnically diverse.

We have a Diversity Council, which consists of leaders representing different facets of our enterprise, to support our overall diversity and inclusion efforts, including in the areas of recruiting, talent development, new-hire mentoring, community partnerships, and educational opportunities. The Diversity Council works to provide tools, guidelines and training with respect to best practices in these areas. In 2021, the Diversity Council provided oversight to our human resources department in the development and implementation of an enterprise-wide inclusive culture training session. In addition, the Diversity Council is in the process of setting up employee resource groups to support team members with similar backgrounds or shared interests. Each employee resource group has an executive sponsor to help in setting a unique mission and operating model.

Competition; Staffing Ratio Requirements—We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the operation of our facilities. There is a limited availability of experienced medical support personnel nationwide, which drives up the 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. This shortage has been exacerbated by the COVID-19 pandemic as more nurses choose to retire early, leave the workforce or take travel assignments. In some areas, the increased demand for care of COVID-19 patients in our hospitals, as well as the direct impact of COVID-19 on physicians, employees and their families, have put a strain on our resources and staff. Over the past two years, we have had to rely on higher-cost temporary and contract labor, which we compete with other healthcare providers to secure, and pay premiums above standard compensation for essential workers.

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, 2021, approximately 27% 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 33 of our hospitals, the majority of which are in California, Florida and Michigan. Organizing activities by labor unions could increase our level of union representation in future periods, which could impact our labor costs.

When we are negotiating collective bargaining agreements with unions (whether such agreements are renewals or first contracts), work stoppages and strikes may occur, as they did at one of our hospitals in 2021. Although relatively uncommon, extended strikes have had, and could in the future have, an adverse effect on our patient volumes, net operating revenues and labor costs at individual hospitals or in local markets.

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 large part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who are members of 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.

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 (1) support through endowments, charitable contributions and tax revenues, (2) access to tax-exempt financing, and (3) 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. Trends toward clinical and pricing transparency may also impact a healthcare facility's competitive position in ways that are difficult to predict.

The existence or absence of 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. In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments and 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.

Another major factor in the competitive position of a hospital or outpatient facility is the scope of its relationships 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. Generally, we compete for managed care 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. Vertical integration efforts involving third-party payers and healthcare providers, among other factors, may increase competitive challenges.

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.

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.

We also recognize that our future success depends, in part, on our ability to maintain and renew our existing managed care contracts and enter into new managed care contracts on competitive 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.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Conifer faces competition from existing participants and new entrants to the revenue cycle management business, 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 perform 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 who offer revenue cycle services, 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

THE AFFORDABLE CARE ACT

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 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.

The healthcare industry, in general, and the acute care hospital business, in particular, have experienced significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to limit, alter or repeal the ACA. Since 2010, various states, private entities and individuals have challenged parts or all of the ACA numerous times in state and federal courts, and the U.S. Supreme Court has issued decisions in three such cases, most recently in June 2021. Various state legislatures have also challenged parts or all of the ACA through legislation, while other states have acted to safeguard the ACA by codifying certain provisions into state law. We cannot predict what future action, if any, Congress might take with respect to the ACA. Furthermore, we are unable to predict the impact on our future revenues and operations of (1) court challenges to the

ACA, (2) administrative, regulatory and legislative changes, including the possibility of 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.

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, 2021, 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 and/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 intend to continue to provide recruitment packages in the future. Furthermore, there can be no assurance that the government will not challenge new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, under 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 should our arrangements fail 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 a 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 enterprise-wide compliance with our HIPAA privacy and security policies and procedures. 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.

THE NO SURPRISES ACT

The No Surprises Act was signed into law in December 2020 as part of the Consolidated Appropriations Act, 2021. The No Surprises Act is intended to address unexpected gaps in insurance coverage that result in "surprise medical bills" when patients unknowingly obtain medical services from physicians and other providers outside their health insurance network, including certain emergency services, anesthesiology services and air ambulance transportation. The protections of the No Surprises Act went into effect on January 1, 2022. As a result, patients will be liable only for their in-network cost-sharing amount, and insurers and providers will be given the opportunity to resolve disputed out-of-network reimbursement through negotiation and an independent dispute resolution process unless state law specifies a different approach. The No Surprises Act does not set a benchmark reimbursement amount.

In July 2021, HHS, along with the U.S. Department of Labor, the U.S. Department of Treasury and the Office of Personnel Management (collectively, the "Agencies") issued "Requirements Related to Surprise Billing; Part I" ("Part I"), an interim final rule implementing several provisions of the No Surprises Act. Part I addresses (1) the ban on balance billing for certain out-of-network services, (2) the notice and consent process that some providers may use to bill patients for out-of-network services, (3) patient cost-sharing calculations, and (4) a complaint process for any potential violations of the provisions in the law. Part I also clarifies that a health plan that provides emergency coverage must provide that coverage without prior authorization, without regard to whether a facility is in-network or out-of-network, and regardless of other terms of the plan, except for exclusions or coordination of benefits. Health plans also cannot deny claims for emergency coverage based on an after-the-fact assessment of the care provided, any purported delay between when symptoms began and when the patient sought care, or based on how long the symptoms were present.

In September 2021, the Agencies released the interim final rule "Requirements Related to Surprise Billing; Part II" ("Part II"), which addresses (1) the independent dispute resolution process that providers and plans may use to adjudicate any outstanding reimbursement disputes, (2) the good-faith cost estimates providers must share with uninsured or self-pay patients for scheduled services, (3) a process to resolve any disputes between uninsured/self-pay patients and providers about the cost estimates, and (4) an external review process as part of the oversight of health plan/issuer compliance with the law and regulations. The Agencies also established a website where an interested party may go to apply to serve as an independent dispute resolution entity and where providers and plans may initiate the process. The provisions in Part I and Part II also went into effect on January 1, 2022.

Many of the provisions of the No Surprises Act impact processes Conifer utilizes to collect accounts receivable, and Conifer has been working with its clients to develop policies and procedures to facilitate compliance. At this time, we are unable to assess the effect that the No Surprises Act or regulations relating to the No Surprises Act might have on our business, financial condition, results of operations or cash flows.

HOSPITAL PRICE TRANSPARENCY RULE

In November 2019, CMS issued a final rule (the "Hospital Price Transparency Rule") requiring that hospitals share payer-specific negotiated prices for certain health care services with the goal of making it easier for consumers to shop and compare prices across hospitals and estimate the cost of care before going to the hospital. The Hospital Price Transparency Rule, which became effective on January 1, 2021, requires each hospital operating in the United States to provide clear, accessible pricing information online about the items and services it provides in two ways: (1) as a comprehensive machine-readable file with all items and services; and (2) in a display of shoppable services in a consumer-friendly format. These requirements apply to hospitals regardless of Medicare enrollment status. In a final rule issued in November 2021, CMS affirmed its commitment to enforcement and public access to pricing information by modifying the Hospital Price Transparency Rule to increase the civil monetary penalties for noncompliance, setting a minimum penalty of $300 per day for smaller hospitals with a bed count of 30 or fewer and a penalty of $10 per bed per day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. Under this approach, the minimum total annual penalty amount would be $109,500 per hospital, and the maximum total annual penalty amount would be $2,007,500 per hospital. CMS began auditing a sample of hospitals for compliance in January 2022, and it will also investigate complaints. We have developed processes to comply with the requirements of the Hospital Price Transparency Rule, and we believe we are in material compliance with those requirements.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

The healthcare industry is subject to heightened and coordinated civil and criminal enforcement efforts from both federal and state government agencies. 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. We have extensive policies and procedures in place to facilitate compliance with the laws, rules and regulations affecting the healthcare industry, however, these policies and procedures cannot ensure compliance in every case.

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

The Social Security Act and Medicare regulations generally require that services that may be paid for under the Medicare program or state healthcare programs 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 Quality Improvement Organization program established under the Social Security Act seeks to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries; to preserve the Medicare Trust Fund by ensuring that Medicare pays only for services that are reasonable and necessary and that are provided in the most appropriate setting; and to protect Medicare beneficiaries by expeditiously addressing complaints, violations under the Emergency Medical Treatment and Active Labor Act, and other quality-related issues.

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 physicians 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 34% 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, 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, 2021.

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, restrictive covenants, 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, which could result in increased costs to consumers. In addition, the FTC has given increased attention to the effect of combinations involving other healthcare providers, including physician practices, as well as to the use of restrictive covenants that limit the ability of employees and others to engage in certain competitive activities. 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 our *Code of Conduct* and obtaining certifications of adherence to the *Code of Conduct* as a condition of employment; (4) maintaining and promoting our Ethics Action Line, a 24-hour, toll-free hotline that allows for confidential reporting of issues on an anonymous basis and emphasizes our 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 we 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 compliance training 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.

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

The healthcare industry has seen significant increases in the cost of professional and general liability insurance due to increased claims and lawsuits in the ordinary course of business. We maintain captive insurance companies to self-insure for the majority of our professional and general liability claims, and we purchase insurance from third parties to cover catastrophic claims. All such commercial insurance we purchase is subject to per-claim and policy period aggregate limits. If the policy period aggregate limit of any of these 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 our professional and general liability 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.

We also purchase property, cybersecurity and other insurance coverage from third parties in amounts we believe are adequate and subject to terms of coverage that we believe are reasonable. Our commercial insurance does not cover all claims against us and may not offset the financial impact of a material loss event. Moreover, commercial insurance may not continue to be available at a reasonable cost for us to maintain at adequate levels. The rise in the number and severity of hurricanes, wildfires, tornadoes and other weather events, whether or not precipitated by climate change, has created increased risk for insurance companies; it is expected that this increased risk will lead to a rise in insurance premiums and reductions in coverage for property owners in the future. In addition, the risk of ransomware attacks, breaches or other disruptions to information technology systems is elevated in the current environment, which has caused an increase in cyber premiums, lower coverage limits and implementation of cyber-specific policies. For further information regarding our insurance coverage, see Note 16 to our Consolidated Financial Statements.

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 (1) the impact of the COVID-19 pandemic, (2) our future earnings, financial position, and operational and strategic initiatives, and (3) 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 volatile 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 trends toward value-based purchasing and alternative payment models;
- The impact of competition, and clinical and price transparency regulations, on our business;
- Our success in recruiting and retaining physicians, nurses and other healthcare professionals as impacted by the COVID-19 pandemic, vaccine mandates and other factors;
- 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;
- Potential security threats, catastrophic events and other disruptions affecting our information technology and related systems;
- Operational and other risks associated with acquisitions, divestitures and joint venture arrangements, including the integration of newly acquired businesses;
- The outcome of the process we have undertaken to pursue a tax-free spin-off of Conifer as a separate, independent, publicly traded company, including the potential that the spin-off may not be completed at all, as well as possible 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 (including inflation), 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 volatile for a significant period of time.

In 2021, the ongoing COVID-19 pandemic significantly affected, and it continues to impact, all three segments of our business, as well as our patients, communities and employees. As a provider of healthcare services, we are acutely affected by the public health and economic effects of the pandemic. Over the course of the last two years, federal, state and local governmental authorities have imposed a variety of restrictions on people and businesses, and public health authorities have offered regular guidance on health and safety, all of which has impacted general economic activity and consumer behavior. More recently, new variants of the virus have caused additional outbreaks, and there is substantial uncertainty about the nature and degree of the continued effects of COVID-19 over time. Known and unknown risks and uncertainties caused by the 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.

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. Restrictive measures, including travel bans, social distancing, quarantines and shelter-in-place orders, have had, and may in the future have, the effect of reducing the number of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits. 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.

In some areas, the increased demand for care of COVID-19 patients in our hospitals, as well as the direct impact of COVID-19 on physicians, employees and their families, have put a strain on our resources and staff. Over the past two years, we have had to rely on higher-cost temporary and contract labor, which we compete with other healthcare providers to secure, and pay premiums above standard compensation for essential workers. Increased demand could also cause some of our hospitals to temporarily reduce their overall operating capacity or suspend certain services. We have incurred and continue to incur additional costs to protect the health and well-being of patients and staff. Even with appropriate protective measures, however, exposure to COVID-19 increases the risk that physicians, nurses and others in our facilities may contract the virus, which could further limit our ability to treat all patients who seek care. If current conditions persist or worsen in some of our markets, certain of our hospitals may experience workforce disruptions from illness, absenteeism or protests. 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 and outbreaks of new variants 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 higher inflation, increased unemployment rates in certain areas in which we operate 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 deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be impacted, and there can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

In general, the extent of the impact of the COVID-19 pandemic on our future operational and financial performance is currently uncertain and will depend on many factors outside of our control, including, among others: the duration, severity and trajectory of the pandemic, including the possible spread of potentially more contagious and/or virulent forms of the virus; future economic conditions, as well as the impact of government actions and administrative regulations on the hospital industry and broader economy, including through existing and any future stimulus efforts; the development, availability and widespread use of effective medical treatments and vaccines; the imposition of public safety measures; the volume of canceled or rescheduled procedures at our facilities; and the volume of COVID-19 patients across our care network. Moreover, at such time as COVID-19 cases do abate, we cannot provide any assurances that our volumes and case mix will return to pre-pandemic levels. COVID-19 developments continue to evolve quickly, and additional developments may occur that we are unable to predict.

Changes to existing 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 for, apply for, receive or benefit from additional financial assistance in the future, if any, or how 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. We are unable to predict whether changes, if any, to existing 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. 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. To the extent we do receive amounts or benefits under future relief measures related to or in response to the COVID-19 pandemic, we cannot predict how such assistance will affect our operations or whether it will offset the negative impacts on our operations arising from the pandemic.

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

The healthcare industry, in general, and the acute care hospital business, in particular, have experienced significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to limit, alter or repeal the ACA. Since 2010, various states, private entities and individuals have challenged parts or all of the ACA numerous times in state and federal courts, and the U.S. Supreme Court has issued decisions in three such cases, most recently in June 2021. Various state legislatures have also challenged parts or all of the ACA through legislation, while other states have acted to safeguard the ACA by codifying certain provisions into state law. We cannot predict what future action, if any, Congress might take with respect to the ACA. Furthermore, we are unable to predict the impact on our future revenues and operations of (1) court challenges to the ACA, (2) administrative, regulatory and legislative changes, including the possibility of 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.

Future 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.

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.

For the year ended December 31, 2021, approximately 18% and 8% of our net patient service revenues 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 and judicial rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating 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. Federal government denials or delayed approvals of waiver applications or extension requests by the states in which we operate could materially impact our Medicaid funding levels. Continuing pressure on state budgets and other factors, including legislative and regulatory changes, could result in future reductions to Medicaid payments, payment delays or changes to Medicaid supplemental payment programs.

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, the healthcare industry 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 partisan divide in Congress. 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 U.S. Department of Justice. 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 commercial insurance does not cover all claims against us. Moreover, commercial insurance may not continue to be available at a reasonable cost for us to maintain at adequate levels. 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 per-claim and policy period aggregate limits. If the policy period aggregate limit of any of these 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 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 competitive 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.

Our future success depends, in part, on our ability to maintain and renew our existing managed care contracts and enter into new managed care contracts on competitive terms. For the year ended December 31, 2021, approximately 68%, or $9.985 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 2021, our commercial managed care net inpatient revenue per admission from the hospitals in our Hospital Operations segment was approximately 82% 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 61% of our managed care net patient service revenues for the year ended December 31, 2021. 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, 2021, 67% 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. 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. 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. Our relationships with payers, and reimbursement for the care we provide, may be further impacted by clinical and price transparency initiatives and out-of-network billing restrictions, including those in the No Surprises Act, which took effect January 1, 2022. In general, any material reductions in the contracted or out-of-network 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 trends 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 requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically, and the number of quality measures hospitals are required to report

publicly has increased in recent years. 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 are also trends 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 trends toward value-based purchasing and alternative payment models will affect our results of operations, but they 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 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 large part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who are members of the medical staffs of those facilities, as well as physicians who affiliate with and use outpatient centers as an extension of their practices.

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 (1) support through endowments, charitable contributions and tax revenues, (2) access to tax-exempt financing, and (3) 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. The existence or absence of state laws that require findings of need for construction and expansion of healthcare facilities or services may also impact competition. In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments and 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.

Another major factor in the competitive position of a hospital or outpatient facility is the scope of its relationships with managed care plans given that 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. Generally, we compete for managed care 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. Vertical integration efforts involving third-party payers and healthcare providers, among other factors, may increase competitive challenges.

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. The No Surprises Act created additional price transparency requirements beginning January 1, 2022, including requiring providers to send to health plans of insured patients and to uninsured patients good faith estimates of the expected charges and diagnostic codes prior to the scheduled dates of services. 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.

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 large part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who are members of 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 areas where we operate physician practices and, where permitted by law, employ physicians. In 2021, we continued to experience challenges in recruiting and retaining physicians as a result of the prioritization of COVID-19 care and the challenges associated with relocating physicians during the pandemic. In some of our markets, physician recruitment and retention are affected by a shortage of qualified physicians in certain higher-demand clinical service lines and specialties. 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 have been, and we expect will continue to 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. There is a limited availability of experienced medical support personnel nationwide, and we compete with other healthcare providers in recruiting and retaining employees. Like others in the healthcare industry, we continue to experience a shortage of critical-care nurses in certain disciplines and geographic areas. This shortage has been exacerbated by the COVID-19 pandemic as more nurses choose to retire early, leave the workforce or take travel assignments. As a result of the aforementioned challenges, we have been and we may continue to be required to enhance wages and benefits to recruit and retain experienced employees, pay premiums above standard compensation for essential workers, make greater investments in education and training for newly licensed medical support personnel, or hire more expensive temporary or contract employees, which we compete with other healthcare providers to secure. 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, 2021, approximately 27% 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 33 of our hospitals, the majority of which are

in California, Florida and Michigan. Organizing activities by labor unions could increase our level of union representation in future periods, which could impact our labor costs.

When we are negotiating collective bargaining agreements with unions (whether such agreements are renewals or first contracts), work stoppages and strikes may occur, as they did at one of our hospitals in 2021. Extended strikes have had, and could in the future have, an adverse effect on our patient volumes, net operating revenues and labor costs at individual hospitals or in local markets.

Employee vaccine mandates may adversely impact our business.

In November 2021, CMS published an interim final rule that requires all staff at healthcare facilities subject to the regulation, except for those with approved medical or religious exemptions, to be vaccinated against COVID-19. On January 13, 2022, the U.S. Supreme Court ruled that CMS had proper legislative authority to issue the mandate, and – although it is still being challenged in the lower courts – the mandate is enforceable while the challenges continue. Following the Supreme Court's decision, CMS released new guidance that will require healthcare workers in 25 states to get their first vaccination in February and their second dose before the end of March 2022. (The CMS guidance did not change the compliance dates for healthcare workers in 25 states where the mandate was already in effect; those workers were required to get their first vaccination by January 27 and be fully vaccinated or exempt from the requirement by February 28.)

We are taking steps to develop policies and procedures to enforce the mandate in all of our hospitals and other healthcare facilities that have not already adopted such a standard. It is currently not possible to predict with certainty the impact the CMS mandate will have on our workforce; however, we recognize that enforcement of the mandate could result in labor disruptions, attrition, including the loss of nurses and other skilled employees, and challenges in meeting future labor needs, which could have a material adverse effect on our ability to treat patients, as well as our financial condition, results of operations or cash flows.

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

Our information technology systems are critical to the day-to-day operation of our business. We rely on our information technology to process, transmit and store clinical, financial and operational data that includes PHI, personally identifiable information, and 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 and other financial systems, supply chain and labor management tools. Our systems, in turn, interface with and rely on third-party systems that we do not control, including medical devices and other processes supporting the interoperability of healthcare infrastructures. 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. However, the information technology and infrastructure we use, and the third-party systems we interact with, 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 attack, breach or other disruption to these systems is elevated in the current environment. In particular, we face a heightened risk of cybersecurity threats targeting healthcare providers, including ransomware attacks.

In general, attacks on, or breaches or other disruptions to, our information technology assets or those of third parties that we rely upon could impact the integrity, security or availability of data we process, transmit or store. 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 continue to be required to expend significant additional resources 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. Our insurance against cyber-risks and attacks 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. An attack, breach or other system disruption 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, system interruption or unavailability of our information systems or of third-party systems with access to our data could result in: the unauthorized disclosure, misuse, loss or corruption 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 condition, results of operations or cash flows.

Any future cost-reduction initiatives may not deliver the benefits we expect, and actions taken may adversely affect our business.

Our future financial performance and level of profitability may depend, in part, on various cost-reduction initiatives, including our outsourcing certain functions unrelated to direct patient care. We may encounter challenges in executing 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. The threat of 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.

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, and in the future expect to be, required to record various charges in our results of operations. Our impairment tests presume stable, improving or, in some cases, declining operating results in our facilities, which are based on programs and initiatives being implemented that are designed to achieve each facility's 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. We believe significant factors that contribute to adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. 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, 2021, we had federal net operating loss ("NOL") carryforwards of approximately $194 million pre-tax available to offset future taxable income. Of these NOL carryforwards, $13 million will expire in the years 2026 to 2036, and $181 million 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 and pursue 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. In April 2021, we divested the majority of our urgent care centers and, in August 2021, we sold five Miami-area hospitals and certain related operations. 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.

We have in the past, and may in the future, fail to obtain applicable regulatory approvals, including FTC approvals, with respect to planned divestitures of assets or businesses. 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 a particular market, which may be material. Many of our acute care hospital divestitures also necessitate us entering into a transition services agreement with the 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 or for transferred contractual liabilities, which could be significant.

Furthermore, our divestiture and other corporate development activities, including the potential spin-off of Conifer, 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.

We have a put/call agreement (the "Baylor Put/Call Agreement") with Baylor that contains put and call options with respect to the 5% ownership interest Baylor holds in USPI. Each year starting in 2021, Baylor may put up to one-third of its total shares in USPI held as of April 1, 2017 (the "Baylor Shares") 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 it could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of Baylor's ownership interest by 2024. We have the

ability to choose whether to settle the purchase price for the Baylor put/call, which is mutually agreed-upon fair market value, in cash or shares of our common stock. Baylor did not deliver a put notice to us in January 2021 or January 2022. In February 2021, we notified Baylor of our intention to exercise our call option to purchase 33.3% of the Baylor Shares. We are continuing to negotiate the terms of that purchase. In February 2022, we notified Baylor of our intention to again exercise our call option to purchase an additional 33.3% of the Baylor Shares. The amount and timing of the payments related to the exercise of our call options in 2021 and 2022, as well as payments related to future put or call decisions under the Baylor Put/Call Agreement, are currently uncertain.

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.

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 of operations 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 of operations 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 are undertaking 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, if consummated, will achieve the business goals or the benefits we expect. Additional risks regarding our divestiture and other corporate development activities, including the potential 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 our earnings and cash flows. Although there can be no assurance that the Conifer spin-off 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.

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 spin-off 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, 2021, we had approximately $15.646 billion of total long-term debt, as well as $139 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 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 2021, our interest expense was $923 million and represented 32% of our $2.871 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 operations are capital intensive and require significant investment to maintain buildings, equipment, software and other assets. Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, as well as 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.

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 physical plant maintenance or operation of 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 have the ability and may decide 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, $1.797 billion was available for borrowing under the Credit Agreement at December 31, 2021. 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, 2021, we had no cash borrowings outstanding under the Credit Agreement, and we had $139 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

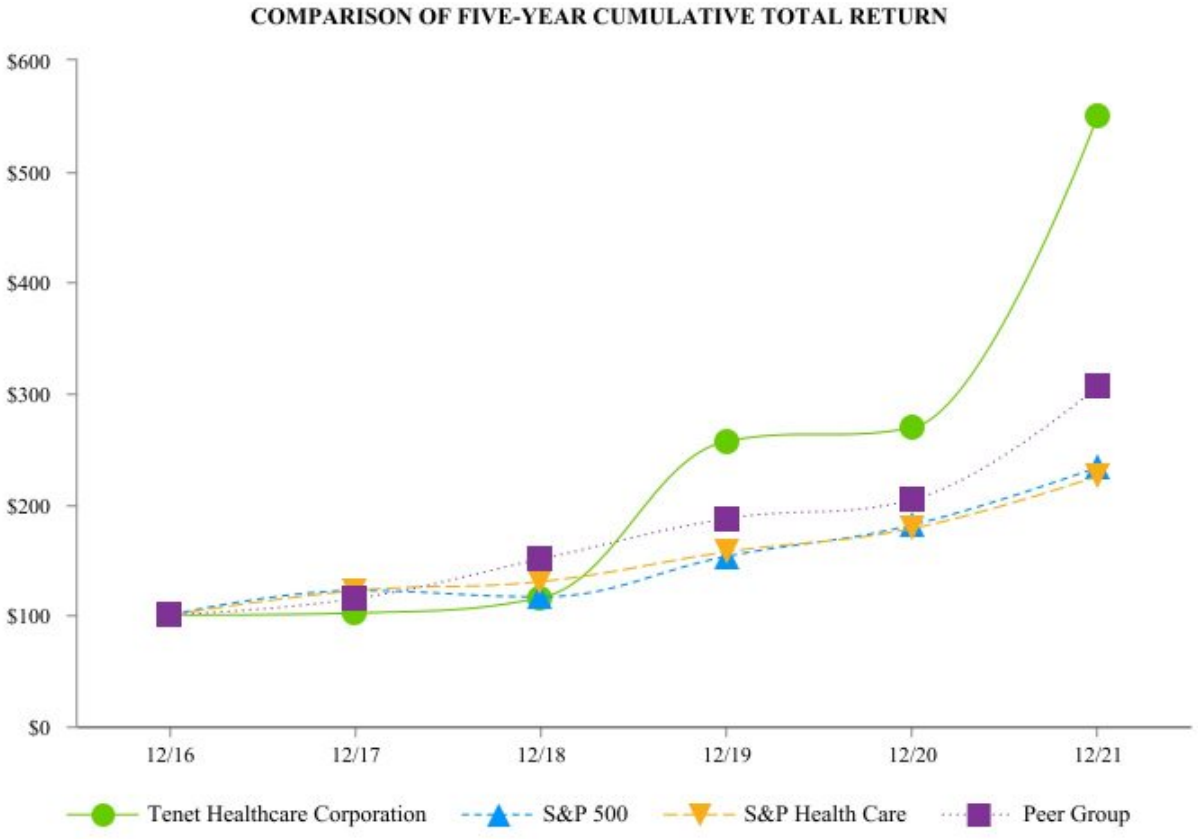
Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." As of February 11, 2022, there were 3,578 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, 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 healthcare provider 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" herein.

Performance data assumes that $100.00 was invested on December 31, 2016 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.



	At December 31,					
	2016	2017	2018	2019	2020	2021
Tenet Healthcare Corporation	$ 100.00	$ 102.16	$ 115.50	$ 256.27	$ 269.07	$ 550.47
S&P 500	$ 100.00	$ 121.83	$ 116.49	$ 153.17	$ 181.35	$ 233.41
S&P Health Care	$ 100.00	$ 122.08	$ 129.97	$ 157.04	$ 178.15	$ 224.70
Peer Group	$ 100.00	$ 114.37	$ 150.52	$ 186.65	$ 203.55	$ 306.40

ITEM 6. RESERVED

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
- Recently Issued Accounting Standards
- Critical Accounting Estimates

Our business consists of our Hospital Operations and other ("Hospital Operations") segment, our Ambulatory Care segment and our Conifer segment. Our Hospital Operations segment is comprised of our acute care and specialty hospitals, imaging centers, ancillary outpatient facilities, micro-hospitals and physician practices. At December 31, 2021, our subsidiaries operated 60 hospitals serving primarily urban and suburban communities in nine states. In April 2021, we completed the sale of the majority of the urgent care centers previously held by our Hospital Operations segment to an unaffiliated urgent care provider. In addition, we completed the sale of five Miami-area hospitals and certain related operations (the "Miami Hospitals") held by our Hospital Operations segment in August 2021.

Our Ambulatory Care segment is comprised of the operations of USPI Holding Company, Inc. ("USPI"), in which we hold an ownership interest of approximately 95%. At December 31, 2021, USPI had interests in 399 ambulatory surgery centers ("ASCs") (249 consolidated) and 24 surgical hospitals (eight consolidated) in 34 states. At December 31, 2020, our Ambulatory Care segment also included 40 urgent care centers that were classified as held for sale and 24 imaging centers. In April 2021, we completed the divestiture of the 40 urgent care centers and transferred the 24 imaging centers to our Hospital Operations segment.

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. subsidiary ("Conifer"). At December 31, 2021, Conifer provided services to approximately 650 Tenet and non-Tenet hospitals and other clients nationwide. Nearly all of the services comprising the operations of our Conifer segment are provided by Conifer Health Solutions, LLC, in which we owned an interest of approximately 76% at December 31, 2021, or by one of its direct or indirect wholly owned subsidiaries.

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 60 hospitals operated throughout the years ended December 31, 2021 and 2020, and the Miami Hospitals we sold in August 2021. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. 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 as a percentage of net operating revenues because a significant portion of our operating expenses are variable. In addition, we present certain metrics on a per-adjusted-patient-admission and per-adjusted-patient-day basis to show trends other than volume.

In certain cases, information presented in MD&A for our Hospital Operations segment is described as presented on a same-hospital basis, which includes the results of our same 60 hospitals operated throughout the years ended December 31, 2021 and 2020, and excludes the results of the Miami Hospitals we sold in August 2021 and the results of our discontinued operations. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Redemption of Senior Secured First Lien Notes—On February 9, 2022, we called for the redemption of all $700 million aggregate principal amount outstanding of our 7.500% senior secured first lien notes due 2025 ("2025 Senior Secured First Lien Notes"). The 2025 Senior Secured First Lien Notes will be redeemed for an anticipated amount of approximately $730 million on February 23, 2022 using cash on hand. We expect this transaction will lower our future annual cash interest payments by approximately $53 million.

Exercise of Call Option to Purchase Additional Ownership Interest in USPI—We have a put/call agreement (the "Baylor Put/Call Agreement") with Baylor University Medical Center ("Baylor") with respect to Baylor's 5% ownership in USPI. In February 2022, we notified Baylor of our intention to exercise our call option under the Baylor Put/Call Agreement to purchase 33.3% of the USPI shares held by Baylor as of April 1, 2017. The amount and timing of the payment related to the exercise of our call option are currently uncertain. See Note 18 to the accompanying Consolidated Financial Statements for additional information related to the Baylor Put/Call Agreement.

IMPACT OF THE COVID-19 PANDEMIC

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 years ended December 31, 2021 and 2020. Restrictive measures, including travel bans, social distancing, quarantines and shelter-in-place orders, reduced the number of procedures performed at our facilities, as well as the volume of emergency room and physician office visits. We began experiencing 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; however, the COVID-19 pandemic generally and, most recently, the spread of the Delta variant and emergence of the Omicron variant continue to impact all three segments of our business, as well as our patients, communities and employees. Broad economic factors resulting from the pandemic, including higher inflation, increased unemployment rates in certain areas in which we operate and reduced consumer spending, continued to impact our patient volumes, service mix and revenue mix in 2021. The pandemic also continued to have an adverse effect on our operating expenses to varying degrees in 2021. As further described below, we have been required to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. In addition, we have experienced significant price increases in medical supplies, particularly for personal protective equipment ("PPE"), and we have encountered supply-chain disruptions, including shortages and delays.

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 years ended December 31, 2021 and 2020, we received cash payments of $215 million and $974 million, respectively, due to grants from the Provider Relief Fund and other state and local grant programs. We recognized $191 million and $882 million, respectively, from these funds as grant income and $14 million and $17 million, respectively, in equity in earnings of unconsolidated affiliates in the accompanying Consolidated Statements of Operations during the years ended December 31, 2021 and 2020.

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 and its future impact on our business remain unknown. For information about risks and uncertainties related to 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 and 2021 due to the COVID-19 pandemic. Although we have seen improvement in our patient volumes, we continue to experience negative impacts of the pandemic on our business in varying degrees. Most recently, in the second half of 2021, we experienced significant acceleration in COVID-19 cases associated with the Delta variant, with a peak in such cases in late August 2021, and the Omicron variant, which emerged in November 2021 to drive a new COVID-19 surge. Throughout the COVID-19 pandemic, we have taken, and we continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues. We have issued new senior unsecured notes and senior secured first lien notes, redeemed existing senior unsecured notes and senior secured first lien notes, including those with the highest interest rate and nearest maturity date of all of our long-term debt, and amended our revolving credit facility. We also decreased our employee headcount throughout the organization at the outset of the COVID-19 pandemic, and we deferred certain operating

expenses that were not expected to impact our response to the pandemic. In addition, we reduced certain variable costs across the enterprise. Together with government relief packages, we believe these actions supported our continued operation during the initial uncertainty caused by the COVID-19 pandemic and continue to do so. For further information on our liquidity, see "Liquidity and Capital Resources" below.

We have experienced, and continue to experience, increased competition with other healthcare providers in recruiting and retaining qualified personnel responsible for the operation of our facilities. There is a limited availability of experienced medical support personnel nationwide, which drives up the 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. This shortage has been exacerbated by the COVID-19 pandemic as more nurses choose to retire early, leave the workforce or take travel assignments. In some areas, the increased demand for care of COVID-19 patients in our hospitals, as well as the direct impact of COVID-19 on physicians, employees and their families, have put a strain on our resources and staff. Over the past two years, we have had to rely on higher-cost temporary and contract labor, which we compete with other healthcare providers to secure, and pay premiums above standard compensation for essential workers. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown; however, we have thus far seen such disruptions continue into 2022, and we expect they may endure through the duration of the pandemic.

We believe that several key trends are also continuing to shape the demand for healthcare services: (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. In addition, the healthcare industry, in general, and the acute care hospital business, in particular, have experienced significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to limit, alter or repeal 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.

Expansion of Our Ambulatory Care Segment—In response to these trends, we continue to focus on opportunities to expand our Ambulatory Care segment through acquisitions, organic growth, construction of new outpatient centers and strategic partnerships. During the years ended December 31, 2021 and 2020, we invested $1.315 billion and $1.200 billion, respectively, to acquire ownership interests in new, or increase our existing ownership in, ambulatory care facilities. This activity included the acquisition of ownership interests in 86 ASCs and related ambulatory support services (collectively, the "SCD Centers") from Surgical Center Development #3, LLC and Surgical Center Development #4, LLC ("SCD") in December 2021. The newly acquired facilities augmented our Ambulatory Care segment's existing musculoskeletal service line and expanded the number of markets it serves. In addition, USPI and SCD's principals entered into a joint venture and development agreement under which USPI will have the exclusive option to partner with affiliates of SCD on the future development of a minimum target of 50 de novo ASCs over a period of five years.

During the year ended December 31, 2021, we also acquired controlling interests in four ASCs in Maryland, two in each of Florida, Georgia and Texas and one in Arizona. We also opened four new ASCs – one each in Montana, Nevada, New Mexico and Tennessee. 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. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

Driving Growth in Our Hospital Systems—We remain 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 measures, comprised primarily of workforce reductions in 2019 (including streamlining corporate overhead and centralized support functions), the consolidation of office locations, and the continuing renegotiation of contracts with suppliers and vendors. Moreover, we established offshore support operations at our Global Business Center ("GBC") in the Philippines. We incurred restructuring charges in conjunction with these initiatives and our cost-saving efforts in response to the COVID-19 pandemic in the years ended December 31, 2021, 2020 and 2019, and we could incur additional such charges if we identify other areas that can be transitioned offshore.

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 April 2021, we divested the majority of our urgent care centers operated under the MedPost and CareSpot brands by our Hospital Operations and Ambulatory Care segments. In addition, we sold our former Miami Hospitals in August 2021. 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.

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, finalization of Conifer's capital structure, the effectiveness of appropriate filings with the SEC, and final approval from our board of directors. Although in March 2021 we entered into a month-to-month agreement amending and updating certain terms and conditions related to the revenue cycle management services Conifer provides to Tenet hospitals ("Amended RCM Agreement"), the execution of a comprehensive amendment to and restatement of the master services agreement between Conifer and Tenet remains an additional prerequisite to the spin-off of Conifer. If consummated, this transaction is expected to potentially enhance shareholder value and, to a lesser degree, the level of Tenet's debt through a tax-free debt-for-debt exchange. There can be no assurance regarding the timeframe for completion of the Conifer 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 it will be completed at all.

Conifer serves approximately 650 Tenet and non-Tenet hospitals 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, if any, 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. During the year ended December 31, 2021, we retired approximately $2.988 billion aggregate principal amount of certain of our senior unsecured notes and senior secured first lien notes. These notes were retired using proceeds from the June 2021 sale of $1.400 billion aggregate principal amount of 4.250% senior secured first lien notes due 2029 (the "2029 Senior Secured First Lien Notes"), the proceeds from the sale of the Miami Hospitals in August 2021 and cash on hand. These transactions reduced future annual cash interest expense payments by approximately $96 million. Moreover, on February 9, 2022, we called for the redemption of all $700 million aggregate principal amount outstanding of our 2025 Senior Secured First Lien Notes. We anticipate redeeming the notes using cash on hand. It remains 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.

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, 2021 and 2020 on a continuing operations basis. The following tables also show information about facilities in our Ambulatory Care segment that we control and, therefore, consolidate.

Selected Operating Statistics	Continuing Operations Three Months Ended December 31, 2021	2020	Increase (Decrease)
Hospital Operations – hospitals and related outpatient facilities:			
Number of hospitals (at end of period)	60	65	(5) (1)
Total admissions	133,809	152,694	(12.4)%
Adjusted patient admissions(2)	241,008	261,097	(7.7)%
Paying admissions (excludes charity and uninsured)	127,092	143,195	(11.2)%
Charity and uninsured admissions	6,717	9,499	(29.3)%
Admissions through emergency department	99,772	114,887	(13.2)%
Emergency department visits, outpatient	531,737	466,179	14.1 %
Total emergency department visits	631,509	581,066	8.7 %
Total surgeries	88,504	95,467	(7.3)%
Patient days — total	713,947	790,522	(9.7)%
Adjusted patient days(2)	1,253,882	1,322,063	(5.2)%
Average length of stay (days)	5.34	5.18	3.1 %
Average licensed beds	15,379	17,203	(10.6)%
Utilization of licensed beds(3)	50.5 %	49.9 %	0.6 % (1)
Total visits	1,451,683	1,441,157	0.7 %
Paying visits (excludes charity and uninsured)	1,364,789	1,350,576	1.1 %
Charity and uninsured visits	86,894	90,581	(4.1)%
Ambulatory Care:			
Total consolidated facilities (at end of period)	257	290	(33) (1)
Total consolidated cases	308,402	566,519	(45.6)%

(1) The change is the difference between the 2021 and 2020 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 18,885, or 12.4%, in the three months ended December 31, 2021 compared to the three months ended December 31, 2020, and total surgeries decreased by 6,963, or 7.3%, in the 2021 period compared to the 2020 period. Total emergency department visits increased 8.7% in the three months ended December 31, 2021 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, 2021 compared to the three months ended December 31, 2020 is primarily attributable to the sale of the Miami Hospitals in August 2021. The decrease of Ambulatory Care total consolidated cases of 45.6% in the three months ended December 31, 2021 compared to the 2020 period is primarily due to the divestiture of USPI's urgent care centers and the realignment of its imaging centers under our Hospital Operations segment.

Revenues	Continuing Operations Three Months Ended December 31, 2021	2020	Increase (Decrease)
Net operating revenues:			
Hospital Operations prior to inter-segment eliminations	$ 3,910	$ 4,065	(3.8) %
Ambulatory Care	742	649	14.3 %
Conifer	324	344	(5.8) %
Inter-segment eliminations	(120)	(143)	(16.1) %
Total	**$ 4,856**	**$ 4,915**	**(1.2) %**

Net operating revenues decreased by $59 million, or 1.2%, in the three months ended December 31, 2021 compared to the same period in 2020, primarily due to the sale of the Miami Hospitals and the divestiture of the urgent care centers previously held by our Hospital Operations and Ambulatory Care segments. During the three months ended December 31, 2021 and 2020, we recognized net grant income of $138 million and $437 million, respectively, which amounts are not included in net operating revenues.

Our accounts receivable days outstanding ("AR Days") from continuing operations were 57.0 days at December 31, 2021 and 55.6 days at December 31, 2020, compared to our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter. This calculation includes our Hospital Operations segment's contract assets. The AR Days calculation excludes (i) urgent care centers operated under the MedPost and CareSpot brands, which we divested in April 2021, (ii) the Miami Hospitals, which we sold in August 2021, and (iii) our California provider fee revenues.

Selected Operating Expenses	Continuing Operations Three Months Ended December 31, 2021	2020	Increase (Decrease)
Hospital Operations:			
Salaries, wages and benefits	$ 1,841	$ 1,892	(2.7) %
Supplies	649	674	(3.7) %
Other operating expenses	875	910	(3.8) %
Total	$ 3,365	$ 3,476	(3.2) %
Ambulatory Care:			
Salaries, wages and benefits	$ 178	$ 171	4.1 %
Supplies	188	149	26.2 %
Other operating expenses	94	91	3.3 %
Total	$ 460	$ 411	11.9 %
Conifer:			
Salaries, wages and benefits	$ 169	$ 162	4.3 %
Supplies	1	1	— %
Other operating expenses	60	70	(14.3) %
Total	$ 230	$ 233	(1.3) %
Total:			
Salaries, wages and benefits	$ 2,188	$ 2,225	(1.7) %
Supplies	838	824	1.7 %
Other operating expenses	1,029	1,071	(3.9) %
Total	$ 4,055	$ 4,120	(1.6) %
Rent/lease expense(1):			
Hospital Operations	$ 71	$ 74	(4.1) %
Ambulatory Care	25	25	— %
Conifer	2	3	(33.3) %
Total	$ 98	$ 102	(3.9) %

(1) Included in other operating expenses.

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended December 31, 2021	2020	Increase (Decrease)
Hospital Operations:			
Salaries, wages and benefits per adjusted patient admission(1)	$ 7,634	$ 7,244	5.4 %
Supplies per adjusted patient admission(1)	2,692	2,583	4.2 %
Other operating expenses per adjusted patient admission(1)	3,632	3,480	4.4 %
Total per adjusted patient admission	**$ 13,958**	**$ 13,307**	**4.9 %**

(1) Calculation excludes the expenses from our now-divested 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 decreased $51 million, or 2.7%, in the three months ended December 31, 2021 compared to the same period in 2020. This change was primarily attributable to the sale of the Miami Hospitals in August 2021 and our continued focus on cost-reduction measures and corporate efficiencies, partially offset by increased contract labor costs, increased overtime expense and annual merit increases for certain of our employees. On a per-adjusted-patient-admission basis, salaries, wages and benefits increased 5.4% in the three months ended December 31, 2021 compared to the three months ended December 31, 2020, primarily due to lower adjusted patient admissions and the expenses mentioned above.

Supplies expense for our Hospital Operations segment decreased $25 million, or 3.7%, during the three months ended December 31, 2021 compared to the three months ended December 31, 2020. This decrease was primarily attributable to the sale of the Miami Hospitals, the decrease in patient volumes during the 2021 period and our cost-efficiency measures, partially offset by increased costs for certain supplies as a result of the COVID-19 pandemic and higher patient acuity. On a per-adjusted-patient-admission basis, supplies expense increased 4.2% in the three months ended December 31, 2021 compared

to the three months ended December 31, 2020, primarily due to higher patient acuity and increased costs of certain supplies as a result of the COVID-19 pandemic.

Other operating expenses for our Hospital Operations segment decreased $35 million, or 3.8%, in the three months ended December 31, 2021 compared to the same period in 2020. The decrease was primarily attributable to the sale of the Miami Hospitals and our cost-efficiency measures. On a per-adjusted-patient-admission basis, other operating expenses in the three months ended December 31, 2021 increased 4.4% compared to the three months ended December 31, 2020. This increase was primarily due to lower adjusted patient admissions and the proportionally higher level of fixed costs (e.g., rent expense) in other operating expenses.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $2.364 billion at December 31, 2021 compared to $2.292 billion at September 30, 2021.

Significant cash flow items in the three months ended December 31, 2021 included:

- Net cash provided by operating activities before interest, taxes, discontinued operations, impairment and restructuring charges, and acquisition-related costs, and litigation costs and settlements of $704 million, including $140 million received from federal, state and local grants, $186 million of Medicare advances recouped and repaid, and a $128 million payment of payroll taxes deferred during 2020;
- Proceeds from the issuance of $1.450 billion aggregate principal amount of our 4.375% senior secured first lien notes due 2030 (the "2030 Senior Secured First Lien Notes"), which were primarily used to acquire the SCD Centers in December 2021;
- $1.156 billion of payments for purchases of businesses or joint venture interests;
- Capital expenditures of $304 million;
- Interest payments of $273 million;
- $107 million of distributions paid to noncontrolling interests;
- Purchase of marketable securities and equity investments of $85 million; and
- $78 million of Medicare advances recouped and repaid by our unconsolidated affiliates for which we provide cash management services.

Net cash provided by operating activities was $1.568 billion in the year ended December 31, 2021 compared to $3.407 billion in the year ended December 31, 2020. Key factors contributing to the change between 2021 and 2020 include the following:

- An increase in operating income of $1.031 billion before net losses on sales, consolidation and deconsolidation of facilities; litigation and investigation costs; impairment and restructuring charges and acquisition-related costs; depreciation and amortization; loss (income) from divested and closed businesses; and income recognized from government relief packages;
- $512 million of Medicare advances recouped and repaid in the year ended December 31, 2021 compared to $1.393 billion of Medicare advances received in the year ended December 31, 2020;
- $178 million of cash received from federal, state and local grants in 2021 compared to $900 million received in 2020;
- A $128 million payment in 2021 of payroll taxes deferred pursuant to COVID-19 legislation compared to the deferral of $260 million of payroll taxes in 2020;
- Lower interest payments of $25 million in 2021;

- Higher income tax payments of $80 million in 2021;
- A decrease of $180 million in payments for restructuring charges, acquisition-related costs, and litigation costs and settlements in 2021; 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:	**2021**	**2020**	**2019**
Medicare	17.7 %	19.8 %	20.1 %
Medicaid	8.5 %	7.9 %	8.3 %
Managed care(1)	67.7 %	66.3 %	66.2 %
Uninsured	1.3 %	1.2 %	0.7 %
Indemnity and other	4.8 %	4.8 %	4.7 %

(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:	**2021**	**2020**	**2019**
Medicare	20.8 %	22.8 %	24.8 %
Medicaid	5.8 %	6.2 %	6.2 %
Managed care(1)	64.4 %	61.8 %	60.3 %
Charity and uninsured	5.8 %	6.3 %	6.0 %
Indemnity and other	3.2 %	2.9 %	2.7 %

(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 63 million individuals rely on healthcare benefits through Medicare, and approximately 83 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 Affordable Care Act extended health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. The expansion of Medicaid in 38 states (including four of the nine states in which we operate acute care hospitals) and the District of Columbia is currently financed through:

- 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.

The ACA also includes measures designed to promote quality and cost efficiency in healthcare delivery and 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 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.

The healthcare industry, in general, and the acute care hospital business, in particular, have experienced significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to limit, alter or repeal the ACA. Since 2010, various states, private entities and individuals have challenged parts or all of the ACA numerous times in state and federal courts, and the U.S. Supreme Court has issued decisions in three such cases, most recently in June 2021. Various state legislatures have also challenged parts or all of the ACA through legislation, while other states have acted to safeguard the ACA by codifying certain provisions into state law. We cannot predict what future action, if any, Congress might take with respect to the ACA. Furthermore, we are unable to predict the impact on our future revenues and operations of (1) court challenges to the ACA, (2) administrative, regulatory and legislative changes, including the possibility of 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. Our total 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 were $2.615 billion, $2.695 billion, and $2.888 billion for the years ended December 31, 2021, 2020 and 2019, respectively.

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, 2021, 49 of our acute care hospitals in continuing operations qualified for Medicare DSH payments.

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 of HHS might take with respect to the DSH calculation for prior periods in this regard or the outcome of the 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 Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") payments. As of December 31, 2021, 30 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, 2021, 19 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, 2021, we operated one freestanding IRF, and 17 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 2021 Medicare FFS improper payment rate for the program is approximately 6.3%. The 2021 error rate for Hospital IPPS payments is approximately 2.4%. CMS has identified the FFS program as a program at risk for significant erroneous payments, and one of the agency's 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 and/or submit quality data every year (and have not applied and qualified for a hardship exception) are subject to a 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 18.7%, 17.8% and 18.4% of the total net patient service revenues of our acute care hospitals and related outpatient facilities for the years ended December 31, 2021, 2020 and 2019, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the years ended December 31, 2021, 2020 and 2019, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately $915 million, $754 million and $782 million, respectively. The year ended December 31, 2021 included $223 million related to the California provider fee program, $254 million related to the Michigan provider fee program, $174 million related to Medicaid DSH programs in multiple states, $71 million related to the Texas Section 1115 waiver program, and $193 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, including legislative and regulatory changes, could result in future reductions to Medicaid payments, payment delays or changes to Medicaid supplemental payment programs. Federal government denials or delayed approvals of waiver applications or extension requests by the states in which we operate could materially impact our Medicaid funding levels.

Total Medicaid and Managed Medicaid net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations segment for the years ended December 31, 2021, 2020 and 2019 were $2.760 billion, $2.427 billion, and $2.639 billion, respectively. During the year ended December 31, 2021, 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. 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.

Regulatory and Legislative Changes

The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative and judicial rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating 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. 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 IPPS annually. The updates generally become effective October 1, the beginning of the federal fiscal year. In August 2021, CMS issued final changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2022 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.7% 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 a 0.7% multifactor productivity reduction required by the ACA and a 0.5% increase required by the Medicare Access and CHIP Reauthorization Act ("MACRA") that collectively result in a net operating payment update of 2.5% before budget neutrality adjustments;

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

- A 1.37% net increase in the capital federal MS-DRG rate;

- An increase in the cost outlier threshold from $29,064 to $30,988;

- An extension of the New COVID-19 Treatments Add-on Payment for certain eligible products through the end of the FFY in which the public health emergency as declared by the Secretary of HHS ends; and

- The establishment of new requirements and the revision of existing requirements for the Hospital Value-Based Purchasing, Hospital Readmissions Reduction and Hospital-Acquired Condition Reduction programs.

According to CMS, the combined impact of the payment and policy changes in the Final IPPS Rule for operating costs will yield an average 2.6% increase in Medicare operating MS-DRG FFS payments for hospitals in urban areas and an average 2.6% increase in such payments for proprietary hospitals in FFY 2022. We estimate that all of the final payment and policy changes affecting operating MS-DRG and UC-DSH payments will result in an estimated 1.4% increase in our annual Medicare FFS IPPS payments, which yields an estimated increase of approximately $27 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 estimates of the impact of the payment and policy changes.

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

In November 2021, CMS issued the final policy changes and payment rates for the Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year ("CY") 2022 ("Final OPPS/ASC Rule"). The Final OPPS/ASC Rule includes the following payment and policy changes:

- An estimated net increase of 2.0% for the OPPS rates based on an estimated market basket increase of 2.7%, reduced by a multifactor productivity adjustment required by the ACA of 0.7%;
- Continuation of the current policy of paying an adjusted amount of average sales price ("ASP") minus 22.5% for drugs acquired under the CMS 340B program (which program is the subject of litigation discussed in greater detail below);
- Cessation of the elimination of the Inpatient Only List ("IPO List") (which is the list of procedures that must be performed on an inpatient basis); efforts to eliminate the IPO List commenced in CY 2021 and were scheduled to be completed over a transitional period ending in CY 2024; in addition, CMS reinstated substantially all of the services removed from the IPO List in CY 2021 to the IPO List beginning in CY 2022;
- Various modifications to the hospital price transparency requirements that took effect on January 1, 2021, including significant increases to the civil monetary penalty for noncompliance, as well as prohibitions to specific barriers to accessing machine-readable price transparency files;
- A 2.0% increase to the ASC payment rates; and
- Reinstatement of the ASC Covered Procedures List ("ASC CPL") criteria in effect in CY 2020 and removal of 255 of the 258 procedures that were proposed for removal.

CMS projects that the combined impact of the proposed payment and policy changes in the Final OPPS/ASC Rule will yield an average 1.6% increase in Medicare FFS OPPS payments for hospitals in urban areas and an average 1.7% 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 $12 million, which represents an increase of approximately 1.8%. 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.

Payment and Policy Changes to the Medicare Physician Fee Schedule

In November 2021, CMS released the CY 2022 MPFS Final Rule ("MPFS Final Rule"). The MPFS Final Rule updates payment policies, payment rates and other provisions for services reimbursed under the MPFS for CY 2022. Under the MPFS Final Rule, the CY 2022 conversion factor, which is the base rate that is used to convert relative units into payment rates, would have been reduced approximately 3.7% due in part to the expiration of the one-time 3.75% MPFS payment increase provided for in CY 2021 by the Consolidated Appropriations Act, 2021 (the "Consolidated Appropriations Act"), as well as budget neutrality rules. However, the Protecting Medicare and American Farmers from Sequester Cuts Act enacted in December 2021 ("December 2021 Legislation") restored 3% of the expired 3.75% payment increase for CY 2022. The combined effects of the MPFS Final Rule and the December 2021 Legislation will result in an annual reduction of approximately $1 million to our FFS MPFS revenues. Because of the uncertainty associated with various factors that may influence our future MPFS payments, including legislative, regulatory 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 Coronavirus Aid, Relief, and Economic Security Act of 2020 and Related Legislation

Several pieces of legislation (the "COVID Acts") have been signed into law in response to the COVID-19 pandemic. Among the numerous provisions included in the legislation is funding to mitigate the economic effects of the COVID-19 pandemic. Below is a brief overview of certain provisions of the COVID Acts 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 statements.

The COVID Acts authorized $178 billion in payments to be distributed to providers through the Provider Relief Fund. Payments from the PRF are not loans and, therefore, they are not subject to repayment. However, as a condition to receiving distributions, providers are required to 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, and we have complied with the reporting requirements.

During the years ended December 31, 2021 and 2020, our Hospital Operations and Ambulatory Care segments combined recognized approximately $176 million and $868 million, respectively, of PRF grant income associated with lost revenues and COVID-related costs. We recognized an additional $14 million and $17 million, respectively, of Provider Relief Fund grant income from our unconsolidated affiliates during 2021 and 2020. Our Hospital Operations and Ambulatory Care segments also recognized $15 million and $14 million of grant income from state and local grant programs during the years ended December 31, 2021 and 2020, respectively. 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 each case in the accompanying Consolidated Statements of Operations for the years ended December 31, 2021 and 2020. At December 31, 2021 and 2020, we had remaining deferred grant payment balances of $5 million and $18 million, respectively, which amounts were recorded in other current liabilities in the accompanying Consolidated Balance Sheets for those periods. We cannot predict whether additional distributions of grant funds will be authorized, and we cannot provide any assurances regarding the amount of grant income, if any, to be recognized in the future.

Medicare and Medicaid Payment Policy Changes—The COVID Acts have also alleviated 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:

- The CMS 2% sequestration reduction on Medicare FFS and Medicare Advantage payments to hospitals, physicians and other providers was suspended effective May 1, 2020 through December 31, 2021. The impact of the suspension on our operations was an increase of approximately $78 million and $67 million of revenues in the years ended December 31, 2021 and 2020, respectively. The December 2021 Legislation extended the suspension of the 2% sequestration reduction through March 31, 2022, to be followed by a 1% reduction for the period April 1, 2022 through June 30, 2022, after which the full 2% reduction will be restored.

- The COVID Acts 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 COVID Acts initially 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. Subsequently, the FFY 2021 DSH reduction was eliminated entirely and the remaining DSH reductions were delayed until FFY 2024.

- The COVID Acts expanded the Medicare accelerated payment program, which provides prepayment of claims to providers in certain circumstances, such as national emergencies or natural disasters. Under Section 2501 of the Continuing Appropriations Act, 2021, and Other Extensions Act, providers may retain the accelerated payments for one year from the date of receipt before CMS commenced recoupment, which is 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% per annum. During the year ended December 31, 2020, our hospitals and other providers applied for and received approximately $1.5 billion of accelerated payments. No additional accelerated payment funds were applied for or received in the year ended December 31, 2021.

- 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. In addition, the COVID Acts established an incentive for states that have not already done so to expand Medicaid by temporarily increasing each such respective state's FMAP for their base program by five percentage points for two years. 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 due to the effects of the pandemic.

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 actual payments received under, or the ultimate impact of, these programs will differ materially from our expectations.

Funding for Uninsured Individuals—The COVID Acts provide 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 may also be used to reimburse providers for COVID-19 vaccine administration to uninsured individuals. We recognized net operating revenues totaling $91 million and $40 million related to this program in the accompanying Consolidated Statements of Operations for the years ended December 31, 2021 and 2020, respectively.

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 COVID Acts provision. In December 2021, we repaid half of the outstanding deferred Social Security tax payments.

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, 19 hospitals in our Hospital Operations segment and three 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 one 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 (that was subsequently extended for an additional three years), called the Comprehensive Care for Joint Replacement ("CJR") model, which includes hip and knee replacements, as well as other major leg procedures. Eleven 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 CMS 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 ("340B Drugs"). In the final rule regarding OPPS payment and policy changes for CY 2018, CMS reduced the payment for 340B Drugs from the ASP plus 6% to the 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. Previously, the U.S. District Court for the District of Columbia (the "District Court") held that the adoption of the 340B Payment Adjustment in the CYs 2018 and 2019 OPPS Final Rules exceeded CMS' statutory authority by reducing drug

reimbursement rates for 340B Hospitals. In July 2020, the U.S. Court of Appeals for the District of Columbia Circuit (the "Appeals 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. The Appeals Court subsequently denied the 340B Hospitals' petition for a rehearing. The 340B Hospitals filed a timely petition asking the U.S. Supreme Court ("Supreme Court") to reverse the Appeals Court's decision and, on July 2, 2021, the Supreme Court agreed to review the case. We cannot predict what further actions the Supreme Court, CMS or Congress might take with respect to the 340B program; however, a reversal of the current payment policy and return to the prior 340B payment methodology could have an adverse effect on our net operating 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, 2021, 2020 and 2019 was $9.985 billion, $9.022 billion and $9.516 billion, respectively. Our top 10 managed care payers generated 61% of our managed care net patient service revenues for the year ended December 31, 2021. In 2021, national payers generated 43% of our managed care net patient service revenues; the remainder came from regional or local payers. At December 31, 2021 and 2020, 67% and 66%, 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, 2021, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $16 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, 2021, our commercial managed care net inpatient revenue per admission from the hospitals in our Hospital Operations segment was approximately 82% 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.

Legislative Changes

As more fully described in Item 1, Business — Healthcare Regulation and Licensing, of Part I of this report, the No Surprises Act ("NSA") and the rules promulgated thereunder went into effect on January 1, 2022. The NSA is intended to address unexpected gaps in insurance coverage that result in "surprise medical bills" when patients unknowingly obtain medical services from physicians and other providers outside their health insurance network, including certain emergency services, anesthesiology services and air ambulance transportation. At this time, we are unable to assess the effect that the NSA or regulations relating to the NSA might have on our business, financial position, results of operations or cash flows.

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, 2021 and 2020, 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 under the Affordable Care Act 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 now-divested health plan businesses) of caring for our uninsured and charity patients:

	Years Ended December 31,		
	2021	2020	2019
Estimated costs for:			
Uninsured patients	$ 650	$ 617	$ 664
Charity care patients	97	147	156
Total	$ 747	$ 764	$ 820

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2021 COMPARED TO THE YEAR ENDED DECEMBER 31, 2020

The following 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, 2021 and 2020. We present metrics as a percentage of net operating revenues because a significant portion of our costs are variable.

	Years Ended December 31,		Increase (Decrease)
	2021	2020	
Net operating revenues:			
Hospital Operations	$ 15,982	$ 14,790	$ 1,192
Ambulatory Care	2,718	2,072	646
Conifer	1,267	1,306	(39)
Inter-segment eliminations	(482)	(528)	46
Net operating revenues	**$ 19,485**	**$ 17,640**	**$ 1,845**
Grant income	**191**	**882**	**(691)**
Equity in earnings of unconsolidated affiliates	**218**	**169**	**49**
Operating expenses:			
Salaries, wages and benefits	8,878	8,418	460
Supplies	3,328	2,982	346
Other operating expenses, net	4,206	4,125	81
Depreciation and amortization	855	857	(2)
Impairment and restructuring charges, and acquisition-related costs	85	290	(205)
Litigation and investigation costs	116	44	72
Net gains on sales, consolidation and deconsolidation of facilities	(445)	(14)	(431)
Operating income	**$ 2,871**	**$ 1,989**	**$ 882**

	Years Ended December 31,		Increase (Decrease)
	2021	2020	
Net operating revenues	100.0 %	100.0 %	— %
Grant income	1.0 %	5.0 %	(4.0) %
Equity in earnings of unconsolidated affiliates	1.1 %	1.0 %	0.1 %
Operating expenses:			
Salaries, wages and benefits	45.6 %	47.8 %	(2.2) %
Supplies	17.1 %	16.9 %	0.2 %
Other operating expenses, net	21.6 %	23.4 %	(1.8) %
Depreciation and amortization	4.4 %	4.9 %	(0.5) %
Impairment and restructuring charges, and acquisition-related costs	0.4 %	1.6 %	(1.2) %
Litigation and investigation costs	0.6 %	0.2 %	0.4 %
Net gains on sales, consolidation and deconsolidation of facilities	(2.3) %	(0.1) %	(2.2) %
Operating income	**14.7 %**	**11.3 %**	**3.4 %**

The following tables present our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, by reportable segment for the years ended December 31, 2021 and 2020:

	Year Ended December 31, 2021		
	Hospital Operations	Ambulatory Care	Conifer
Net operating revenues	**$ 15,500**	**$ 2,718**	**$ 1,267**
Grant income	**142**	**49**	**—**
Equity in earnings of unconsolidated affiliates	**25**	**193**	**—**
Operating expenses:			
Salaries, wages and benefits	7,511	690	677
Supplies	2,640	684	4
Other operating expenses, net	3,586	389	231
Depreciation and amortization	722	95	38
Impairment and restructuring charges, and acquisition-related costs	39	27	19
Litigation and investigation costs	100	14	2
Net gains on sales, consolidation and deconsolidation of facilities	(411)	(34)	—
Operating income	**$ 1,480**	**$ 1,095**	**$ 296**

	Year Ended December 31, 2021		
	Hospital Operations	Ambulatory Care	Conifer
Net operating revenues	100.0 %	100.0 %	100.0 %
Grant income	0.9 %	1.8 %	— %
Equity in earnings of unconsolidated affiliates	0.2 %	7.1 %	— %
Operating expenses:			
Salaries, wages and benefits	48.5 %	25.4 %	53.4 %
Supplies	17.0 %	25.2 %	0.3 %
Other operating expenses, net	23.2 %	14.3 %	18.2 %
Depreciation and amortization	4.7 %	3.5 %	3.0 %
Impairment and restructuring charges, and acquisition-related costs	0.3 %	1.0 %	1.5 %
Litigation and investigation costs	0.6 %	0.5 %	0.2 %
Net gains on sales, consolidation and deconsolidation of facilities	(2.7) %	(1.3) %	— %
Operating income	**9.5 %**	**40.3 %**	**23.4 %**

	Year Ended December 31, 2020		
	Hospital Operations	Ambulatory Care	Conifer
Net operating revenues	**$ 14,262**	**$ 2,072**	**$ 1,306**
Grant income	**823**	**59**	**—**
Equity in earnings of unconsolidated affiliates	**6**	**163**	**—**
Operating expenses:			
Salaries, wages and benefits	7,136	609	673
Supplies	2,511	468	3
Other operating expenses, net	3,513	349	263
Depreciation and amortization	739	81	37
Impairment and restructuring charges, and acquisition-related costs	187	57	46
Litigation and investigation costs	33	6	5
Net losses (gains) on sales, consolidation and deconsolidation of facilities	1	(15)	—
Operating income	**$ 971**	**$ 739**	**$ 279**

	Year Ended December 31, 2020		
	Hospital Operations	Ambulatory Care	Conifer
Net operating revenues	100.0 %	100.0 %	100.0 %
Grant income	5.8 %	2.8 %	— %
Equity in earnings of unconsolidated affiliates	— %	7.9 %	— %
Operating expenses:			
Salaries, wages and benefits	50.0 %	29.4 %	51.5 %
Supplies	17.6 %	22.6 %	0.2 %
Other operating expenses, net	24.7 %	16.7 %	20.2 %
Depreciation and amortization	5.2 %	3.9 %	2.8 %
Impairment and restructuring charges, and acquisition-related costs	1.3 %	2.8 %	3.5 %
Litigation and investigation costs	0.2 %	0.3 %	0.4 %
Net losses (gains) on sales, consolidation and deconsolidation of facilities	— %	(0.7) %	— %
Operating income	**6.8 %**	**35.7 %**	**21.4 %**

Total net operating revenues increased by $1.845 billion, or 10.5%, for the year ended December 31, 2021 compared to the year ended December 31, 2020. Hospital Operations net operating revenues, net of inter-segment eliminations, increased by $1.238 billion, or 8.7%, for the year ended December 31, 2021 compared to 2020, primarily due to increased patient volumes, higher patient acuity, a more favorable payer mix and improved terms of our managed care contracts, partially offset by the sale of our former Miami Hospitals in August 2021.

Ambulatory Care net operating revenues increased by $646 million, or 31.2%, for the year ended December 31, 2021 compared to 2020. The change was primarily due to an increase from acquisitions of $476 million and same-facility growth of $307 million, which was attributable to the impact of higher patient volumes and acuity, incremental revenue from new service lines and negotiated commercial rate increases. These impacts were partially offset by a decrease of $137 million due to the sale of the Ambulatory Care segment's urgent care centers and the transfer of its imaging centers to the Hospital Operations segment.

Conifer net operating revenues decreased by $39 million, or 3.0%, for the year ended December 31, 2021 compared to 2020. Conifer revenues from third-party customers, which revenues are not eliminated in consolidation, increased $7 million, or 0.9%, for the year ended December 31, 2021 compared to 2020.

The following table shows selected operating expenses of our three reportable operating segments. Information for our Hospital Operations segment is presented on a same-hospital basis, whereas information presented for our Ambulatory Care and Conifer segments is presented on a continuing operations basis.

Selected Operating Expenses	Years Ended December 31, 2021	2020	Increase (Decrease)
Hospital Operations — Same-Hospital:			
Salaries, wages and benefits	$ 7,227	$ 6,685	8.1 %
Supplies	2,532	2,353	7.6 %
Other operating expenses	3,375	3,229	4.5 %
Total	$ 13,134	$ 12,267	7.1 %
Ambulatory Care:			
Salaries, wages and benefits	$ 690	$ 609	13.3 %
Supplies	684	468	46.2 %
Other operating expenses	389	349	11.5 %
Total	$ 1,763	$ 1,426	23.6 %
Conifer:			
Salaries, wages and benefits	$ 677	$ 673	0.6 %
Supplies	4	3	33.3 %
Other operating expenses	231	263	(12.2) %
Total	$ 912	$ 939	(2.9) %
Rent/lease expense[1]:			
Hospital Operations	$ 280	$ 257	8.9 %
Ambulatory Care	100	92	8.7 %
Conifer	10	12	(16.7) %
Total	$ 390	$ 361	8.0 %

(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, imaging centers, ancillary outpatient facilities, micro-hospitals and physician practices;
- Our Ambulatory Care segment is comprised of USPI's ASCs and surgical hospitals; and
- 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:

Admissions, Patient Days and Surgeries	Same-Hospital Years Ended December 31, 2021	2020	Increase (Decrease)	
Number of hospitals (at end of period)	60	60	—	(1)
Total admissions	547,754	548,569	(0.1)%	
Adjusted patient admissions(2)	973,552	950,789	2.4 %	
Paying admissions (excludes charity and uninsured)	518,515	518,042	0.1 %	
Charity and uninsured admissions	29,239	30,527	(4.2)%	
Admissions through emergency department	409,440	398,708	2.7 %	
Paying admissions as a percentage of total admissions	94.7 %	94.4 %	0.3 %	(1)
Charity and uninsured admissions as a percentage of total admissions	5.3 %	5.6 %	(0.3)%	(1)
Emergency department admissions as a percentage of total admissions	74.7 %	72.7 %	2.0 %	(1)
Surgeries — inpatient	141,469	144,421	(2.0)%	
Surgeries — outpatient	216,011	192,600	12.2 %	
Total surgeries	357,480	337,021	6.1 %	
Patient days — total	2,888,928	2,798,386	3.2 %	
Adjusted patient days(2)	5,016,029	4,707,262	6.6 %	
Average length of stay (days)	5.27	5.10	3.3 %	
Licensed beds (at end of period)	15,379	15,403	(0.2)%	
Average licensed beds	15,396	15,446	(0.3)%	
Utilization of licensed beds(3)	51.4 %	49.5 %	1.9 %	(1)

(1) The change is the difference between 2021 and 2020 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.

Outpatient Visits	Same-Hospital Years Ended December 31, 2021	2020	Increase (Decrease)	
Total visits	5,319,994	4,598,483	15.7 %	
Paying visits (excludes charity and uninsured)	4,964,084	4,285,043	15.8 %	
Charity and uninsured visits	355,910	313,440	13.5 %	
Emergency department visits	2,034,405	1,846,361	10.2 %	
Surgery visits	216,011	192,600	12.2 %	
Paying visits as a percentage of total visits	93.3 %	93.2 %	0.1 %	(1)
Charity and uninsured visits as a percentage of total visits	6.7 %	6.8 %	(0.1)%	(1)

(1) The change is the difference between 2021 and 2020 amounts shown.

Revenues	Same-Hospital Years Ended December 31, 2021	2020	Increase (Decrease)
Total segment net operating revenues(1)	$ 14,768	$ 13,272	11.3 %
Selected revenue data – hospitals and related outpatient facilities:			
Net patient service revenues(1)(2)	$ 14,043	$ 12,655	11.0 %
Net patient service revenue per adjusted patient admission(1)(2)	$ 14,424	$ 13,310	8.4 %
Net patient service revenue per adjusted patient day(1)(2)	$ 2,800	$ 2,688	4.2 %

(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 Years Ended December 31, 2021	2020	Increase (Decrease)	
Salaries, wages and benefits as a percentage of net operating revenues	48.9 %	50.4 %	(1.5)%	(1)
Supplies as a percentage of net operating revenues	17.1 %	17.7 %	(0.6)%	(1)
Other operating expenses as a percentage of net operating revenues	22.9 %	24.3 %	(1.4)%	(1)

(1) The change is the difference between 2021 and 2020 amounts shown.

Revenues

Same-hospital net operating revenues increased $1.496 billion, or 11.3%, during the year ended December 31, 2021 compared to the year ended December 31, 2020, primarily due to increased patient and surgical volumes, higher patient acuity, a more favorable payer mix and negotiated commercial rate increases. Our Hospital Operations segment also recognized grant income from federal, state and local grants totaling $142 million and $823 million in the years ended December 31, 2021 and 2020, respectively, which is not included in net operating revenues. Same-hospital admissions during the year ended December 31, 2021 were consistent with the year ended December 31, 2020, while outpatient visits increased 15.7% and same-hospital adjusted admissions increased 2.4% year-over-year.

The following table shows the consolidated net accounts receivable by payer at December 31, 2021 and 2020:

	December 31, 2021	2020
Medicare	$ 155	$ 152
Medicaid	47	49
Net cost report settlements receivable and valuation allowances	33	34
Managed care	1,602	1,567
Self-pay uninsured	21	32
Self-pay balance after insurance	70	74
Estimated future recoveries	137	156
Other payers	331	318
Total Hospital Operations	2,396	2,382
Ambulatory Care	374	307
Total discontinued operations	—	1
Accounts receivable, net	**$ 2,770**	**$ 2,690**

Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2021, our Hospital Operations segment collection rate on self-pay accounts was approximately 26.5%. 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, 2021, 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 96.6% at December 31, 2021.

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 $2.363 billion and $2.348 billion at December 31, 2021 and 2020, respectively, excluding cost report settlements receivable and valuation allowances of $33 million and $34 million, respectively, at December 31, 2021 and 2020:

	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
At December 31, 2021:					
0-60 days	93 %	35 %	57 %	22 %	52 %
61-120 days	4 %	31 %	18 %	14 %	16 %
121-180 days	1 %	14 %	10 %	9 %	9 %
Over 180 days	2 %	20 %	15 %	55 %	23 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**
At December 31, 2020:					
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 %**

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, 2021, we had a cumulative total of patient account assignments to Conifer of $1.932 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables; 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 Eligibility and Enrollment Services program ("EES") 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 EES, net of appropriate implicit price concessions. Based on recent trends, approximately 97% of all accounts in the EES are ultimately approved for benefits under a government program, such as Medicaid.

The following table shows the approximate amount of accounts receivable in the EES still awaiting determination of eligibility under a government program at December 31, 2021 and 2020 by aging category:

	December 31,	
	2021	2020
0-60 days	$ 87	$ 91
61-120 days	17	24
121-180 days	4	6
Over 180 days	7	6
Total	**$ 115**	**$ 127**

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits increased $542 million, or 8.1%, in the year ended December 31, 2021 compared to 2020. This increase was primarily attributable to higher patient volumes, increased contract labor costs, increased overtime expense, annual merit increases for certain of our employees and higher incentive compensation. Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased by 150 basis points to 48.9% in the year ended December 31, 2021 compared to the year ended December 31, 2020, primarily due higher patient acuity and cost-reduction measures, including the use of labor management tools as volumes fluctuate. Salaries, wages and benefits expense for the year ended December 31, 2021 and 2020 included stock-based compensation expense of $41 million and $28 million, respectively.

Supplies

Same-hospital supplies expense increased $179 million, or 7.6%, in the year ended December 31, 2021 compared to 2020. The increase was primarily due to higher patient volumes, the increased cost of certain supplies as a result of the COVID-19 pandemic and growth in our higher-acuity, supply-intensive surgical services. Same-hospital supplies expense as a percentage of net operating revenues decreased by 60 basis points to 17.1% in the year ended December 31, 2021 compared to the year ended December 31, 2020, primarily due to the growth of our higher-margin services and our cost-efficiency measures.

The COVID-19 pandemic has created supply-chain disruptions, including shortages and delays, as well as significant price increases in medical supplies, particularly for PPE. 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 cardiac stents and pacemakers, orthopedics, implants and high-cost pharmaceuticals.

Other Operating Expenses, Net

Same-hospital other operating expenses increased by $146 million, or 4.5%, in the year ended December 31, 2021 compared to 2020. Same-hospital other operating expenses as a percentage of net operating revenues decreased by 140 basis points to 22.9% in the year ended December 31, 2021 compared to 24.3% in the year ended December 31, 2020, primarily due to higher patient volumes and the growth of our net operating revenues. The changes in other operating expenses included:

- increased malpractice expense of $60 million;
- increased rent and lease expense of $22 million;
- increased collection fees of $19 million;
- increased software costs of $17 million;
- increased repair and maintenance costs of $17 million; and
- a gain on sale and leaseback of a medical office building of $12 million, which was classified as a reduction of other operating expenses, net.

Ambulatory Care Segment

Our Ambulatory Care segment is comprised of USPI's ASCs 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 and administrative 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 (166 of 423 facilities at December 31, 2021), 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 257 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 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 61% 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, 2021 Compared to the Year Ended December 31, 2020

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

	Years Ended December 31,		
Ambulatory Care Results of Operations	**2021**	**2020**	**Increase (Decrease)**
Net operating revenues	$ 2,718	$ 2,072	31.2 %
Grant income	$ 49	$ 59	(16.9) %
Equity in earnings of unconsolidated affiliates	$ 193	$ 163	18.4 %
Salaries, wages and benefits	$ 690	$ 609	13.3 %
Supplies	$ 684	$ 468	46.2 %
Other operating expenses, net	$ 389	$ 349	11.5 %

Revenues

Our Ambulatory Care net operating revenues increased by $646 million, or 31.2%, during the year ended December 31, 2021 compared to 2020. The change was driven by an increase from acquisitions of $476 million, as well as an increase in same-facility net operating revenues of $307 million, which was attributable to the impact of higher patient volumes and acuity, incremental revenue from new service lines and negotiated commercial rate increases. These impacts were partially offset by a decrease of $137 million, due primarily to the sale of USPI's urgent care centers and the transfer of imaging centers to the Hospital Operations segment. Our Ambulatory Care segment also recognized grant income from federal grants totaling

$49 million and $59 million during the years ended December 31, 2021 and 2020, respectively, which is not included in net operating revenues.

Salaries, Wages and Benefits

Salaries, wages and benefits expense increased by $81 million, or 13.3%, during the year ended December 31, 2021 compared to 2020. Salaries, wages and benefits expense was impacted by an increase from acquisitions of $79 million and an increase in same-facility salaries, wages and benefits expense of $57 million due primarily to higher surgical patient volumes. These increases were partially offset by a decrease of $55 million due to the sale of USPI's urgent care centers, the transfer of imaging centers to the Hospital Operations segment and the deconsolidation of a facility. Salaries, wages and benefits expense as a percentage of net operating revenues decreased 400 basis points during the year ended December 31, 2021 compared to 2020. This decrease was primarily attributable to higher surgical patient volumes and acuity, as well as staffing alignment and cost-reduction measures. Salaries, wages and benefits expense for the years ended December 31, 2021 and 2020 included stock-based compensation expense of $13 million and $14 million, respectively.

Supplies

Supplies expense increased by $216 million, or 46.2%, during the year ended December 31, 2021 compared to 2020. The change was driven by an increase from acquisitions of $143 million, as well as an increase in same-facility supplies expense of $82 million due primarily to an increase in surgical cases at our consolidated centers, higher costs driven by the higher level of patient acuity, and higher pricing of certain supplies as a result of the COVID-19 pandemic, partially offset by a decrease of $9 million due to the sale of USPI's urgent care centers, the transfer of imaging centers to the Hospital Operations segment and the deconsolidation of a facility. Supplies expense as a percentage of net operating revenues increased 260 basis points from 22.6% in the year ended December 31, 2020 to 25.2% in the year ended December 31, 2021. This change was driven by an increase in higher-acuity, supply-intensive surgeries and higher pricing of certain supplies as a result of the COVID-19 pandemic.

Other Operating Expenses, Net

Other operating expenses increased by $40 million, or 11.5%, during the year ended December 31, 2021 compared to 2020. The change was driven by an increase from acquisitions of $52 million, as well as an increase in same-facility other operating expenses of $27 million, partially offset by a decrease of $39 million due to the sale of USPI's urgent care centers and the transfer of imaging centers to the Hospital Operations segment. Other operating expenses, net as a percentage of net operating revenues decreased from 16.7% during the year ended December 31, 2020 to 14.3% for 2021, primarily due to higher patient volumes, an increase in our net operating revenues and our cost-efficiency measures.

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, 2021**
Net revenues	14.5%
Cases	15.6%
Net revenue per case	(1.0)%

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, 2021, the majority of facilities in our Ambulatory Care segment are operated in this model.

The table below summarizes the amounts we paid to acquire various ownership interests in ambulatory care facilities in the periods indicated:

	Years Ended December 31,		
Type of Ownership Interests Acquired	**2021**	**2020**	**Increase (Decrease)**
Controlling interests	$ 1,219	$ 1,175	$ 44
Noncontrolling interests	79	24	55
Equity investment in unconsolidated affiliates and consolidated facilities	17	1	16
	$ 1,315	$ 1,200	$ 115

The table below provides information about the ownership structure of the facilities our Ambulatory Care segment operated at December 31, 2021:

Ambulatory Care Facilities	**December 31, 2021**
Ownership Structure:	
With a health system partner	196
Without a health system partner	227
Total facilities operated	**423**

The table below reflects changes in the number of facilities operated during the year ended December 31, 2021:

Ambulatory Care Facilities	**Year Ended December 31, 2021**
Change from December 31, 2020:	
Acquisitions	91
De novo	4
Dispositions/Mergers	(68)
Total increase in number of facilities operated	**27**

Through our transaction with SCD in December 2021, we acquired majority ownership interests in six SCD Centers and minority ownership interests in 80 SCD Centers, along with other related ambulatory support services, for a cash payment of $1.048 billion. Since that initial closing, we have separately made offers, and continue to make offers in an ongoing process, to acquire a portion of the equity interests in certain of the SCD Centers from the physician owners for consideration of up to approximately $250 million; before the end of 2021, we had completed purchases of physician equity resulting in the consolidation in our financial statements of an additional 10 SCD Centers for aggregate payments of $77 million. At December 31, 2021, we held controlling interests in 15 SCD Centers and noncontrolling interests in 57 SCD Centers. The remaining 14 SCD Centers were acquired in the development stage and, therefore, are not included in total acquisitions in the table above. We cannot reasonably predict how many additional physician owners will accept our offers to acquire a portion of their equity, nor the timing or amount of any related payments. We will consolidate in our financial statements the results of the centers in which USPI acquires a majority ownership position.

During the year ended December 31, 2021, we also acquired controlling interests in four ASCs in Maryland, two in each of Florida, Georgia and Texas, and one in Arizona. We paid cash totaling approximately $73 million for these acquisitions. The ASC acquired in Arizona and one of the Florida centers are jointly owned with a health system partner and physicians. The remaining nine ASCs are jointly owned with physicians. During 2021, we obtained a controlling interest in three surgical hospitals in Arizona in which we previously owned a noncontrolling interest for $13 million. We own one of the hospitals with a health system partner and the remaining two hospitals with a health system and physician partners.

In addition to the those acquired through the SCD acquisition, we acquired noncontrolling interests in four ASCs in Florida, two ASCs in North Carolina, and one each in New Mexico and Texas during the year ended December 31, 2021. We paid cash totaling approximately $79 million for these acquisitions. Following our initial investment, we purchased additional ownership interests in two of the ASCs in Florida for $8 million and subsequently consolidated them. We own the ASC

acquired in New Mexico and one of the ASCs acquired in North Carolina jointly with a health system and physician partners, and the remaining six centers are jointly owned with physicians.

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 in control. These transactions are primarily the acquisitions of equity interests in ASCs and the investment of additional cash in facilities that need capital for new acquisitions, new construction or other business growth opportunities. During the year ended December 31, 2021, we invested approximately $17 million in such transactions.

During the year ended December 31, 2021, we transferred all 24 imaging centers held in our Ambulatory Care segment to our Hospital Operations segment, divested 40 urgent care centers and sold a portion of our ownership in two ASCs in which we previously had a controlling interest to a health system for approximately $12 million, resulting in the deconsolidation of those facilities.

Conifer Segment

Revenues

Our Conifer segment generated net operating revenues of $1.267 billion and $1.306 billion during the years ended December 31, 2021 and 2020, respectively. The decline in Conifer's net operating revenues of $39 million, or 3.0%, was primarily due to the revised terms in the Amended RCM Agreement, partially offset by client volume improvement in 2021 compared to 2020, as well as new business expansion. Conifer revenues from third-party customers, which revenues are not eliminated in consolidation, increased $7 million, or 0.9%, for the year ended December 31, 2021 compared to 2020. The increase was primarily driven by the transition of the Miami Hospitals sold in August 2021 to a third-party customer and new business expansion, partially offset by expected client attrition.

The Amended RCM Agreement updated certain terms and conditions related to the revenue cycle management services Conifer provides to Tenet hospitals. Conifer's contract with Tenet represented 38.0% of the net operating revenues Conifer recognized in the year ended December 31, 2021.

Salaries, Wages and Benefits

Salaries, wages and benefits expense for Conifer increased $4 million, or 0.6%, in the year ended December 31, 2021 compared to 2020. Salaries, wages and benefits expense included stock-based compensation expense of $2 million in both 2021 and 2020.

Other Operating Expenses, Net

Other operating expenses for Conifer decreased $32 million, or 12.2%, in the year ended December 31, 2021 compared to 2020. This decrease was attributable to reduced pass-through costs associated with the Amended RCM Agreement and a reduction of legal expenses.

Consolidated

Impairment and Restructuring Charges, and Acquisition-Related Costs

The following table provides information about our impairment and restructuring charges, and acquisition-related costs:

	Years Ended December 31,	
	2021	2020
Consolidated:		
Impairment charges	$ 8	$ 92
Restructuring charges	57	184
Acquisition-related costs	20	14
Total impairment and restructuring charges, and acquisition-related costs	**$ 85**	**$ 290**
By segment:		
Hospital Operations	$ 39	$ 187
Ambulatory Care	27	57
Conifer	19	46
Total impairment and restructuring charges, and acquisition-related costs	**$ 85**	**$ 290**

Impairment charges for the year ended December 31, 2021 were comprised of $5 million from our Ambulatory Care segment, primarily related to the impairment of certain management contract intangible assets, and $3 million from our Conifer segment. Restructuring charges during the year ended December 31, 2021 consisted of $14 million of employee severance costs, $19 million related to the transition of various administrative functions to our GBC and $24 million of other restructuring costs. Acquisition-related costs consisted of $20 million of transaction costs for the year ended December 31, 2021.

Impairment charges during the year ended December 31, 2020 primarily 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 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. For additional discussion see Note 6 to the accompanying Consolidated Financial Statements.

Restructuring charges for the year ended December 31, 2020 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 for the year ended December 31, 2020.

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 each facility's 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.

Litigation and Investigation Costs

Litigation and investigation costs for the years ended December 31, 2021 and 2020 were $116 million and $44 million, respectively, primarily related to costs associated with legal proceedings and governmental investigations. See Note 17 to the accompanying Consolidated Financial Statements for additional information.

Net Gains on Sales, Consolidation and Deconsolidation of Facilities

During the year ended December 31, 2021, we recorded net gains on sales, consolidation and deconsolidation of facilities of $445 million, primarily comprised of a gain of $406 million related to the sale of the Miami Hospitals in August 2021, a gain of $14 million related to the sale of the majority of our urgent care centers in April 2021, net gains of $22 million related to consolidation changes of certain USPI businesses due to ownership changes and net gains of $3 million related to other activity.

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.

Interest Expense

Interest expense for the year ended December 31, 2021 was $923 million compared to $1.003 billion for the year ended December 31, 2020, primarily due to the early redemption of all $1.410 billion aggregate principal amount outstanding of our 5.125% senior secured second lien notes due 2025 (the "2025 Senior Secured Second Lien Notes") in June 2021 and early retirement of all $478 million aggregate principal amount outstanding of our 7.000% senior unsecured notes due 2025 ("2025 Senior Unsecured Notes") in March 2021.

Loss from Early Extinguishment of Debt

Loss from early extinguishment of debt was $74 million for the year ended December 31, 2021 and consisted of aggregate losses incurred from the redemption of our 4.625% senior secured first lien notes due 2024 ("2024 Senior Secured First Lien Notes") in September 2021, the redemption of our 2025 Senior Secured Second Lien Notes in June 2021 and the retirement of our 2025 Senior Unsecured Notes in March 2021, all in advance of their respective maturity dates. See Note 8 to the accompanying Consolidated Financial Statements for additional information.

Loss from early extinguishment of debt was $316 million for the year ended December 31, 2020 and consisted of an aggregate loss of $320 million from the redemption and purchase of our 8.125% senior unsecured notes due 2022, partially offset by $4 million of gains on the extinguishment of mortgage notes.

Income Tax Expense

During the year ended December 31, 2021, we recorded income tax expense of $411 million in continuing operations on pre-tax income of $1.888 billion compared to an income tax benefit of $97 million in continuing operations on pre-tax income of $671 million during the year ended December 31, 2020.

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,	
	2021	2020
Tax expense at statutory federal rate of 21%	$ 396	$ 141
State income taxes, net of federal income tax benefit	77	33
Expired state net operating losses, net of federal income tax benefit	—	1
Tax benefit attributable to noncontrolling interests	(114)	(75)
Nondeductible goodwill	35	—
Nondeductible executive compensation	8	6
Nondeductible litigation costs	1	—
Expired charitable contribution carryforward	—	1
Stock-based compensation tax benefits	(5)	(2)
Changes in valuation allowance	2	(226)
Prior-year provision to return adjustments and other changes in deferred taxes	8	14
Other items	3	10
Income tax expense (benefit)	**$ 411**	**$ (97)**

As a result of the change in the business interest expense disallowance rules under the COVID Acts, 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 $562 million for the year ended December 31, 2021 compared to $369 million for the year ended December 31, 2020. Net income available to noncontrolling interests in 2021 was comprised of $448 million of income related to our Ambulatory Care segment, $69 million of income related to our Conifer segment and $45 million of income related to our Hospital Operations segment. Of the portion related to our Ambulatory Care segment, $21 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., 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 to Tenet Healthcare Corporation common shareholders (the most comparable GAAP term) for the years ended December 31, 2021 and 2020:

	Years Ended December 31,	
	2021	2020
Net income available to Tenet Healthcare Corporation common shareholders	$ 914	$ 399
Less: Net income available to noncontrolling interests	(562)	(369)
Loss from discontinued operations, net of tax	(1)	—
Income from continuing operations	1,477	768
Income tax benefit (expense)	(411)	97
Loss from early extinguishment of debt	(74)	(316)
Other non-operating income, net	14	1
Interest expense	(923)	(1,003)
Operating income	2,871	1,989
Litigation and investigation costs	(116)	(44)
Net gains on sales, consolidation and deconsolidation of facilities	445	14
Impairment and restructuring charges, and acquisition-related costs	(85)	(290)
Depreciation and amortization	(855)	(857)
Income (loss) from divested and closed businesses (i.e. health plan businesses)	(1)	20
Adjusted EBITDA	**$ 3,483**	**$ 3,146**
Net operating revenues	**$ 19,485**	**$ 17,640**
Less: Net operating revenues from health plans	**—**	**21**
Adjusted net operating revenues	**$ 19,485**	**$ 17,619**
Net income available to Tenet Healthcare Corporation common shareholders as a % of net operating revenues	**4.7 %**	**2.3 %**
Adjusted EBITDA as % of adjusted net operating revenues (Adjusted EBITDA margin)	**17.9 %**	**17.9 %**

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

A discussion of the results of operations for the year ended December 31, 2020 compared to the year ended December 31, 2019 can be found in our Annual Report on Form 10-K for the year ended December 31, 2020.

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Scheduled Contractual Obligations

Our obligations to make future cash payments under contracts are summarized in the table below, all as of December 31, 2021. Other than the repayment of long-term debt, we expect to use net cash generated from operating activities, cash on hand or borrowings under our revolving credit facility to satisfy the below obligations. Long-term debt maturities may be refinanced or repaid using net cash generated from operating activities or from the proceeds from sales of facilities.

		Years Ended December 31,					
	Total	2022	2023	2024	2025	2026	Later Years
				(In Millions)			
Long-term debt(1)	$ 19,986	$ 851	$ 2,698	$ 2,121	$ 1,359	$ 2,664	$ 10,293
Finance lease obligations(1)	350	116	76	48	16	11	83
Long-term non-cancelable operating leases	1,368	236	211	185	156	124	456
Medicare accelerated payment program	880	880	—	—	—	—	—
Academic teaching services	315	63	63	63	63	63	—
Defined benefit plan obligations	486	25	23	23	23	23	369
Information technology contract services	546	214	203	119	2	2	6
Purchase orders	335	335	—	—	—	—	—
Total	**$ 24,266**	**$ 2,720**	**$ 3,274**	**$ 2,559**	**$ 1,619**	**$ 2,887**	**$ 11,207**

(1) Amounts include both principal and interest.

Long-term Debt—We have a senior secured revolving credit facility (as amended to date, the "Credit Agreement") that provides for revolving loans in an aggregate principal amount of up to $1.900 billion with a $200 million subfacility for standby letters of credit. Any amounts outstanding under the Credit Agreement are due upon the facility's maturity in September 2024. At December 31, 2021, we had no cash borrowings outstanding under the Credit Agreement and less than $1 million of standby letters of credit outstanding.

At December 31, 2021, we had outstanding senior unsecured and senior secured notes ("Senior Notes") with an aggregate principal balance of $15.354 billion. The Senior Notes generally require semi-annual interest payments and have maturity dates ranging from 2023 through 2031. Any outstanding principal and accrued but unpaid interest is due upon maturity.

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2021:

- In December 2021, we issued $1.450 billion aggregate principal amount of our 2030 Senior Secured First Lien Notes. We will pay interest on these notes semi-annually in arrears on January 15 and July 15 of each year, commencing in July 2022. We used the net proceeds from the issuance of the 2030 Senior Secured First Lien Notes, after payment of fees and expenses, to finance the acquisition of the SCD Centers in December 2021 and for general corporate purposes.

- In September 2021, we redeemed approximately $1.100 billion of the then-outstanding $1.870 billion aggregate principal amount of our 2024 Senior Secured First Lien Notes in advance of their maturity date. We paid $1.113 billion to redeem the notes, which was primarily funded with the proceeds from the sale of the Miami Hospitals in August 2021. In connection with the redemption, we recorded a loss from early extinguishment of debt of $20 million in the three months ended September 30, 2021, primarily related to the difference between the purchase price and the par value of the notes, as well as the write-off of associated unamortized issuance costs.

- In June 2021, we issued $1.400 billion aggregate principal amount of our 2029 Senior Secured First Lien Notes. We pay interest on the 2029 Senior Secured First Lien Notes semi-annually in arrears on June 1 and December 1 of each year, which payments commenced in December 2021. The proceeds from the sale of the 2029 Senior Secured First Lien Notes were used, after payment of fees and expenses, together with cash on hand, to finance the redemption of all $1.410 billion aggregate principal amount then outstanding of our 2025 Senior Secured Second Lien Notes in advance of their maturity date for approximately $1.428 billion. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $31 million in the three

months ended June 30, 2021, primarily related to the difference between the purchase price and the par value of the 2025 Senior Secured Second Lien Notes, as well as the write-off of associated unamortized issuance costs.

- In March 2021, we retired all $478 million aggregate principal amount outstanding of our 2025 Senior Unsecured Notes in advance of their maturity date. We paid approximately $495 million from cash on hand to retire the notes. In connection with the retirement, we recorded a loss from early extinguishment of debt of $23 million in the three months ended March 31, 2021, primarily related to the difference between the purchase price and the par value of the notes, as well as the write-off of associated unamortized issuance costs.

At December 31, 2021, 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 3.81x, or 4.07x if adjusted to include outstanding obligations arising from cash advances received from Medicare pursuant to the COVID Acts. 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 continue to evaluate opportunities to retire, purchase, redeem and refinance outstanding debt subject to prevailing market conditions, our liquidity requirements, operating results, contractual restrictions and other factors. In the year ending December 31, 2023 and beyond, we may also consider share repurchases depending on market conditions and other investment opportunities. 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.

Interest payments, net of capitalized interest, were $937 million, $962 million and $946 million in the years ended December 31, 2021, 2020 and 2019, respectively. For the year ending December 31, 2022, we expect annual interest payments to be approximately $850 million to $860 million.

On February 9, 2022, we called for the redemption of all $700 million aggregate principal amount outstanding of our 2025 Senior Secured First Lien Notes. We anticipate redeeming the notes using cash on hand. We expect this transaction will lower our annual cash interest payments by approximately $53 million, which savings are reflected in the expected annual interest payments above.

Future maturities of our long-term debt obligations are summarized in the table above. See Note 8 to the accompanying Consolidated Financial Statements for additional information about our long-term debt obligations.

Lease Obligations—We have operating lease agreements primarily for real estate, including off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices, as well as for medical office equipment. Our finance leases are primarily for medical equipment and information technology and telecommunications assets. As of December 31, 2021, we had fixed payment obligations of $1.407 billion under non-cancellable lease agreements. Future payments due in connection with our operating and finance leases, including imputed interest, are summarized in the table above. Additional information about our lease commitments is provided in Note 7 to the accompanying Consolidated Financial Statements.

Medicare Accelerated Payment Program—As further discussed in Note 1 to the accompanying Consolidated Financial Statements, we received advance payments from the Medicare accelerated payment program following its expansion under the COVID Acts. As of December 31, 2021, we had a liability of $880 million related to advances received under the Medicare accelerated payment program that will be recouped during the year ending December 31, 2022 through reductions of our Medicare claims payments.

Academic Teaching Services—We enter into contracts for academic teaching services with university and physician groups to support graduate medical education. These agreements contain various rights and termination provisions.

Defined Benefit Obligations—We maintain three frozen, non-qualified defined benefit plans that provide supplemental retirement benefits to certain of our current and former executives. These plans are unfunded, and plan obligations are paid from our working capital. We also maintain a frozen, qualified defined benefit plan that benefits certain of our employees in Detroit. See Note 10 to the accompanying Consolidated Financial Statements for additional information about our defined benefit plans.

Information Technology Contracts—We enter into various non-cancellable contracts for information technology services and licenses as a normal part of our business. These contracts generally relate to information technology infrastructure support and services, software licenses for certain operational and administrative systems, and cybersecurity-related software and services.

Purchase Orders—We had outstanding short-term purchase commitments of $335 million at December 31, 2021, which we expect to pay within 12 months.

Other Contractual Obligations

Asset Retirement Obligations—Asset retirement obligations represent the estimated costs to perform environmental remediation work, which we are legally obligated to complete, at certain of our facilities upon their retirement. This work could include asbestos abatement, the removal of underground storage tanks and other similar activities. At December 31, 2021, the undiscounted aggregate future estimated payments related to these obligations was $185 million. We are unable to predict the timing of these payments due to the uncertainty and long timeframes inherent in these obligations.

Standby Letters of Credit—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 have a letter of credit facility (as amended, the "LC Facility") that provides for the issuance of standby and documentary letters of credit. The aggregate principal amount of letters of credit that from time to time may be issued under the LC Facility is $200 million. Drawings under any letter of credit issued under the LC Facility accrue interest if not reimbursed within three business days. At December 31, 2021, we had $139 million of standby letters of credit outstanding under the LC Facility. The timing of reimbursement payments is uncertain, as we cannot foresee when, or if, a standby letter of credit will be drawn upon.

Guarantees—Our guarantees include minimum revenue guarantees, primarily related to physicians under relocation agreements and physician groups that provide services at our hospitals, as well as operating lease guarantees. At December 31, 2021, the maximum potential amount of future payments under these guarantees was $216 million, of which $116 million were recorded in the accompanying Consolidated Balance Sheet at December 31, 2021. The timing and amount of future payments under these guarantees is uncertain.

Professional and General Liability Obligations—At December 31, 2021, the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were $254 million and $791 million, respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were $43 million and $107 million, respectively. The timing of professional and general liability payments is uncertain as such payments depend on several factors, including the nature of claims and when they are received.

Baylor Put/Call Agreement—As further discussed in Note 18 to the accompanying Consolidated Financial Statements, we have a put/call agreement with Baylor with respect to Baylor's 5% ownership in USPI. Each year starting in 2021, Baylor may put up to one-third of its total shares in USPI held as of April 1, 2017 (the "Baylor Shares") 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 it could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of Baylor's ownership interest by 2024. We have the ability to choose whether to settle the purchase price for the Baylor put/call, which is mutually agreed-upon fair market value, in cash or shares of our common stock. The carrying value of the redeemable noncontrolling interests in USPI that are subject to the Baylor Put/Call Agreement was $258 million at December 31, 2021.

Baylor did not deliver a put notice to us in January 2021 or January 2022. In February 2021, we notified Baylor of our intention to exercise our call option to purchase 33.3% of the Baylor Shares. We are continuing to negotiate the terms of that purchase. In addition, in February 2022, we notified Baylor of our intention to again exercise our call option to purchase an additional 33.3% of the Baylor Shares. The amount and timing of the payments related to the exercise of our call options in 2021 and 2022, as well as payments related to future put or call decisions under the Baylor Put/Call Agreement, are currently uncertain.

SCD Development Agreement—In November 2021, USPI and SCD's principals entered into a joint venture and development agreement under which USPI will have the exclusive option to partner with affiliates of SCD on the future development of a minimum target of 50 de novo ASCs over a period of five years. The timing and amount of payments related to the development of these facilities is currently unknown.

Investment in the SCD Centers—Beginning in December 2021, USPI made offers, and it continues to make offers in an ongoing process, to acquire a portion of the equity interests in certain of the SCD Centers from the physician owners for consideration of up to approximately $250 million. Before the end of 2021, we made aggregate payments of $77 million to acquire majority ownership interests in 10 SCD Centers. We cannot reasonably predict how many additional physician owners will accept our offers to acquire a portion of their equity, nor the timing or amount of any remaining payments. We expect to fund these payments using cash on hand.

Other than the obligations described above, we had 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 at December 31, 2021.

Other Cash Requirements

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 $658 million, $540 million and $670 million in the years ended December 31, 2021, 2020 and 2019, respectively. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2022 will total approximately $725 million to $775 million, including $95 million that was accrued as a liability at December 31, 2021.

As previously reported, we are building a 100-bed acute-care hospital and a medical office building in Fort Mill, South Carolina, which we expect to open in August 2022. We expect construction of the Fort Mill campus will cost approximately $150 million over the construction period, of which $51 million was expended as of December 31, 2021. In San Antonio, we are planning to break ground on a new healthcare campus in Westover Hills in 2022, inclusive of a hospital, ASC and medical office space. We expect construction of the Westover Hills facilities will cost approximately $260 million over the construction period.

Income tax payments, net of tax refunds, were $92 million in year ended December 31, 2021 and $12 million in both the years ended December 31, 2020 and 2019. At December 31, 2021, our carryforwards available to offset future taxable income consisted of (1) federal NOL carryforwards of approximately $194 million pre-tax, $13 million of which expires in 2026 to 2036 and $181 million of which has no expiration date, (2) general business credit carryforwards of approximately $9 million expiring in 2034 through 2038, (3) charitable contribution carryforwards of approximately $90 million expiring in 2024 through 2025 and (4) state NOL carryforwards of approximately $3.333 billion expiring in 2022 through 2041 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $49 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, 2017 remain subject to audit by the IRS.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2021 was primarily derived from net cash provided by operating activities and cash on hand. During 2021, we also received $215 million, including $37 million received by our unconsolidated affiliates, of supplemental funds from federal, state and local grants provided under the COVID Acts. We had $2.364 billion of cash and cash equivalents on hand at December 31, 2021 to fund our operations and capital expenditures, and our borrowing availability under our Credit Agreement was $1.797 billion based on our borrowing base calculation at December 31, 2021.

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. Our revolving credit facility provides additional liquidity to manage fluctuations in operating cash caused by these factors.

Net cash provided by operating activities was $1.568 billion in the year ended December 31, 2021 compared to $3.407 billion in the year ended December 31, 2020. Key factors contributing to the change between 2021 and 2020 include the following:

- An increase in operating income of $1.031 billion before net losses on sales, consolidation and deconsolidation of facilities; litigation and investigation costs; impairment and restructuring charges and acquisition-related costs; depreciation and amortization; loss (income) from divested and closed businesses; and income recognized from government relief packages;
- $512 million of Medicare advances recouped and repaid in the year ended December 31, 2021 compared to $1.393 billion of Medicare advances received in the year ended December 31, 2020;
- $178 million of cash received from federal, state and local grants in 2021 compared to $900 million received in 2020;
- A $128 million payment in 2021 of payroll taxes deferred pursuant to the COVID Acts compared to the deferral of $260 million of payroll taxes in 2020;
- Lower interest payments of $25 million in 2021;
- Higher income tax payments of $80 million in 2021;
- A decrease of $180 million in payments for restructuring charges, acquisition-related costs, and litigation costs and settlements in 2021; and
- The timing of other working capital items.

Net cash used in investing activities was $714 million for the year ended December 31, 2021 compared to $1.608 billion for the year ended December 31, 2020. The 2021 activity included an increase in proceeds from the sale of facilities and other assets of $1.171 billion compared to 2020, primarily related to the sale of the majority of our urgent care centers in April 2021 and the sale of the Miami Hospitals in August 2021. This increase was partially offset by increased capital expenditures of $118 million and an increase of $64 million in purchases of equity interests in unconsolidated affiliates during the year ended December 31, 2021 compared to the year ended December 31, 2020. We made aggregate payments of $1.220 billion during the year ended December 31, 2021 to acquire businesses, primarily for the purchase of ownership interests in the SCD Centers. During the year ended December 31, 2020 we paid $1.177 billion to acquire businesses, primarily related to our acquisition of ownership interests in 45 ASCs from affiliates of SCD.

Net cash used in financing activities was $936 million for the year ended December 31, 2021 compared to net cash provided by financing activities of $385 million for the year ended December 31, 2020. During the year ended December 31, 2021, we issued $2.850 billion aggregate principal amount of senior secured first lien notes and used a portion of the proceeds, together with the proceeds from our sale of the Miami Hospitals and cash on hand, to redeem and retire $2.988 billion aggregate principal amount of our then-outstanding senior unsecured and senior secured first lien notes. Financing activity in 2021 also included the receipt of $37 million of grant funds by our Ambulatory Care segment's unconsolidated affiliates and their repayment of $104 million of Medicare advances. Additionally, we paid total distributions to noncontrolling interest holders of $423 million during the year ended December 31, 2021.

During the year ended December 31, 2020, we issued $3.800 billion aggregate principal amount of senior unsecured and senior secured first lien notes and paid $3.099 billion to redeem and purchase $2.800 billion aggregate principal amount then outstanding of our senior notes. Additionally, our Ambulatory Care segment's non-consolidated affiliates received $74 million of grant funds and $113 million of cash advances from Medicare.

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, 2021, we were paying approximately 6,300 vendors under these programs, with an annual charge volume of approximately $1.2 billion. 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—At December 31, 2021, our Credit Agreement provided for revolving loans in an aggregate principal amount of up to $1.900 billion with a $200 million subfacility for standby letters of credit. In April 2020, we amended our Credit Agreement to, among other things, (i) increase the aggregate revolving credit commitments from $1.500 billion to $1.900 billion (the "Increased Commitments"), 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 April 2021, we further amended the Credit Agreement to, among other things, extend the availability of the Increased Commitments through April 22, 2022 and reduce the interest rate margins. 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, 2021, 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, $1.797 billion was available for borrowing at December 31, 2021. At December 31, 2021, we were in compliance with all covenants and conditions in our Credit Agreement. See Note 8 to the accompanying Consolidated Financial Statements for additional information about our Credit Agreement.

Letter of Credit Facility—In March 2020, we amended our LC Facility to extend the scheduled maturity date 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 incrementally increase the maximum secured debt covenant from 4.25 to 1.00 on a quarterly basis up to 6.00 to 1.00 for the quarter ended March 31, 2021, at which point the maximum ratio began to step down incrementally on a quarterly basis through the quarter ended December 31, 2021. At December 31, 2021, the effective maximum secured debt covenant was 4.25 to 1.00, where it will remain until maturity. 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, 2021, we were in compliance with all covenants and conditions in the LC Facility. At December 31, 2021, we had $139 million of standby letters of credit outstanding under the LC Facility.

Senior Secured Note Issuances and Debt Refinancing Transactions. In 2021, we sold $2.850 billion aggregate principal amount of senior secured first lien notes – specifically, our 2029 Senior Secured First Lien Notes in June 2021 and our 2030 Senior Secured First Lien Notes in December 2021. The net proceeds from these note issuances was primarily used to redeem our 2025 Senior Secured Second Lien Notes in June 2021 and to finance the acquisition of the SCD Centers in December 2021.

During the year ended December 31, 2021, we paid $3.036 billion to redeem and/or retire $2.988 billion aggregate principal amount then outstanding of senior unsecured and senior secured notes in advance of their respective maturity dates. We used the net proceeds from the June 2021 issuance of our 2029 Senior Secured First Lien Notes, after payment of fees and expenses, the proceeds from the sale of the Miami Hospitals and cash on hand to finance these transactions. We recognized an aggregate loss from early extinguishment of debt of $74 million in the year ended December 31, 2021, primarily related to the difference between the purchase prices and the par values of the notes, as well as the write-off of associated unamortized issuance costs.

LIQUIDITY

Broad economic factors resulting from the COVID-19 pandemic, including higher inflation, increased unemployment rates in certain areas in which we operate and reduced consumer spending, continued to impact our service mix, revenue mix and patient volumes in 2021. Business closings and layoffs in the areas we operate have led to increases in the uninsured and underinsured populations; higher uninsured and underinsured populations 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 deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be impacted.

Throughout the COVID-19 pandemic, we have taken, and we continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues. These actions included the sale and redemption of various senior unsecured and senior secured notes, which eliminated any significant debt maturities until June 2023 and reduced our required annual cash interest payments. In April 2021, we further amended our Credit Agreement to extend the availability of the Increased Commitments through April 22, 2022. In addition, we have continued to focus on cost-reduction measures and corporate efficiencies to substantially offset incremental costs, including temporary staffing and premium pay, as well as higher supply costs for PPE. We have also sought to compensate for the COVID-19 pandemic's disruption of our patient volumes and mix by growing our services for which demand has been more resilient, including our higher-acuity service lines, and we expect demand for these higher-acuity service lines will continue to grow in the future. We believe all of these actions, together with government relief packages, supported our continued operation during the initial uncertainty caused by the COVID-19 pandemic and continue to do so.

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 may 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 and anticipated future cash provided by our operating activities 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 balance sheet. 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.

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 before 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, 2021, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $16 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, 2021, a 10% increase or decrease in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in a favorable or unfavorable 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.

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, 2021, a 500 basis point increase in our frequency trend would increase the estimated reserves by $47 million, and a 500 basis point decrease in our frequency trend would decrease the estimated reserves by $37 million. A 500 basis point increase in our severity trend would increase the estimated reserves by $190 million, and a 500 basis point decrease in our severity trend would decrease the estimated reserves by $131 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, 2021 and 2020:

	December 31,	
	2021	**2020**
Case reserves	$ 387	$ 273
Incurred but not reported and loss development reserves	658	705
Total reserves	**$ 1,045**	**$ 978**

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, 2021 and 2020 representing unsettled claims was approximately 98% and 99%, 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,	
	2021	2020
Accrual for professional and general liability claims, beginning of the year	$ 978	$ 965
Less losses recoverable from re-insurance and excess insurance carriers	(50)	(86)
Expense related to:(1)		
Current year	200	195
Prior years	131	120
Total incurred loss and loss expense	331	315
Paid claims and expenses related to:		
Current year	(13)	(3)
Prior years	(239)	(263)
Total paid claims and expenses	(252)	(266)
Plus losses recoverable from re-insurance and excess insurance carriers	38	50
Accrual for professional and general liability claims, end of year	**$ 1,045**	**$ 978**

(1) Total malpractice expense for continuing operations, including premiums for insured coverage and recoveries from third parties, was $355 million and $320 million in the years ended December 31, 2021 and 2020, 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 an asset group 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 asset group, we calculate the amount of an impairment charge only if the carrying value of the asset group exceeds the fair value. For purposes of impairment testing, all asset groups are evaluated at a level below that of the reporting unit, and their carrying values do not include any allocations of goodwill. The fair values of assets are 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 those assets. The estimates of these future net cash flows are based on assumptions and projections we believe to be reasonable and supportable. Estimates require our subjective judgments and take into account assumptions about revenue and expense growth rates, operating margins and recoverable disposition values, based on industry and operating factors. These assumptions may vary by type of asset group and presume stable, improving or, in some cases, declining results, 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, 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, physician recruitment and retention, 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;
- the nature of the ultimate disposition of the assets; and
- macro-economic conditions such as inflation, GDP growth and unforeseen technological advancements.

During the year ended December 31, 2021, we recorded $8 million of impairment charges, primarily related to the write-down of certain indefinite-lived management contracts within our Ambulatory Care segment to their estimated fair values. Of the total impairment charges recognized for the year ended December 31, 2021, $5 million related to our Ambulatory Care segment and $3 million related to our Conifer segment.

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.

In our most recent impairment analysis as of December 31, 2021, we had one asset group, including two hospitals and related operations, with an aggregate carrying value of $224 million whose estimated undiscounted future cash flows exceeded the carrying value by approximately 188%. 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 purchase price over the net estimated fair value of identifiable assets acquired and liabilities assumed in a business combination. Goodwill is determined to have an indefinite useful life and is not amortized, but is instead subject to impairment tests performed at least annually, or when events occur that would more likely than not reduce the fair value of the reporting unit below its carrying amount. For goodwill, we assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. Further testing is required only if we determine, based on the qualitative assessment, that it is more likely than not that a reporting unit's fair value is less than its carrying value. Otherwise no further impairment testing is required. 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, with any impairment not to exceed the carrying amount of goodwill. Any impairment would be recognized as a charge to income from operations and a reduction in the carrying value of goodwill.

At December 31, 2021, our business included three reportable segments – Hospital Operations, Ambulatory Care and Conifer. Our reportable segments are reporting units used to perform our goodwill impairment analysis, and goodwill is accordingly assigned to these reporting segments. We completed our annual impairment tests for goodwill as of October 1, 2021.

The allocated goodwill balance related to our Hospital Operations segment totals $2.808 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.

The allocated goodwill balance related to our Ambulatory Care segment totals $5.848 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.

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 above analyses included recent and estimated future operating trends derived from macro-economic conditions, industry conditions and other factors specific to each reporting segment.

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, 2021, the valuation allowance increased by $2 million, including an increase of $2 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 $2 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2021 was $57 million. 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 remaining balance in the valuation allowance at December 31, 2020 was $55 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, 2021. 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 end of the reporting period. The effects of unamortized discounts and issue costs are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2022	2023	2024	2025	2026	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed-rate long-term debt	$ 135	$ 1,983	$ 1,446	$ 742	$ 2,120	$ 9,371	$ 15,797	$ 16,323
Average effective interest rates	4.3 %	6.6 %	4.6 %	7.4 %	4.9 %	5.4 %	5.5 %	

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, 2021. 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, 2021.

Tenet's internal control over financial reporting as of December 31, 2021 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, 2021, 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/ SAUMYA SUTARIA
Saumya Sutaria, M.D.
Chief Executive Officer
February 18, 2022

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Executive Vice President and Chief Financial Officer
February 18, 2022

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, 2021, 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, 2021, 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, 2021 of the Company and our report dated February 18, 2022, expressed an unqualified opinion on those financial statements.

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 18, 2022

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, 2021, and 2020, 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, 2021, 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, 2021, and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021, 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, 2021, 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 18, 2022, 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.

Net Operating Revenues and Accounts Receivable - 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, 2021, the balances for net operating revenues, of which approximately 93% is net patient service revenues, and accounts receivable were $19.485 billion and $2.770 billion, respectively. The 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.

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, 2021, the accrual for professional and general liability reserves was $1.045 billion. 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 judgments.

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, to derive a range of projections of ultimate losses, and compared our estimates to management's estimates.

/s/ DELOITTE & TOUCHE LLP

Dallas, Texas
February 18, 2022

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

CONSOLIDATED BALANCE SHEETS
Dollars in Millions

	December 31, 2021	December 31, 2020
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,364	$ 2,446
Accounts receivable	2,770	2,690
Inventories of supplies, at cost	384	368
Assets held for sale	—	140
Other current assets	1,557	1,503
Total current assets	**7,075**	**7,147**
Investments and other assets	3,254	2,534
Deferred income taxes	65	325
Property and equipment, at cost, less accumulated depreciation and amortization ($5,960 at December 31, 2021 and $6,043 at December 31, 2020)	6,427	6,692
Goodwill	9,261	8,808
Other intangible assets, at cost, less accumulated amortization ($1,374 at December 31, 2021 and $1,284 at December 31, 2020)	1,497	1,600
Total assets	**$ 27,579**	**$ 27,106**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 135	$ 145
Accounts payable	1,300	1,207
Accrued compensation and benefits	896	942
Professional and general liability reserves	254	243
Accrued interest payable	203	248
Liabilities held for sale	—	70
Contract liabilities	959	659
Other current liabilities	1,362	1,333
Total current liabilities	**5,109**	**4,847**
Long-term debt, net of current portion	15,511	15,574
Professional and general liability reserves	791	735
Defined benefit plan obligations	421	497
Deferred income taxes	36	29
Contract liabilities – long-term	15	918
Other long-term liabilities	1,439	1,617
Total liabilities	**23,322**	**24,217**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	2,203	1,952
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 155,520,691 shares issued at December 31, 2021 and 154,407,524 shares issued at December 31, 2020	8	7
Additional paid-in capital	4,877	4,844
Accumulated other comprehensive loss	(233)	(281)
Accumulated deficit	(1,214)	(2,128)
Common stock in treasury, at cost, 48,331,649 shares at December 31, 2021 and 48,337,947 shares at December 31, 2020	(2,410)	(2,414)
Total shareholders' equity	**1,028**	**28**
Noncontrolling interests	**1,026**	**909**
Total equity	**2,054**	**937**
Total liabilities and equity	**$ 27,579**	**$ 27,106**

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2021	2020	2019
Net operating revenues	**$ 19,485**	**$ 17,640**	**$ 18,479**
Grant income	**191**	**882**	**—**
Equity in earnings of unconsolidated affiliates	**218**	**169**	**175**
Operating expenses:			
Salaries, wages and benefits	8,878	8,418	8,698
Supplies	3,328	2,982	3,057
Other operating expenses, net	4,206	4,125	4,171
Depreciation and amortization	855	857	850
Impairment and restructuring charges, and acquisition-related costs	85	290	185
Litigation and investigation costs	116	44	141
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(445)	(14)	15
Operating income	**2,871**	**1,989**	**1,537**
Interest expense	(923)	(1,003)	(985)
Other non-operating income (expense), net	14	1	(5)
Loss from early extinguishment of debt	(74)	(316)	(227)
Income from continuing operations, before income taxes	**1,888**	**671**	**320**
Income tax benefit (expense)	(411)	97	(160)
Income from continuing operations, before discontinued operations	**1,477**	**768**	**160**
Discontinued operations:			
Income (loss) from operations	(1)	—	15
Income tax expense	—	—	(4)
Income (loss) from discontinued operations	**(1)**	**—**	**11**
Net income	**1,476**	**768**	**171**
Less: Net income available to noncontrolling interests	562	369	386
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 914**	**$ 399**	**$ (215)**
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders			
Income (loss) from continuing operations, net of tax	$ 915	$ 399	$ (226)
Income (loss) from discontinued operations, net of tax	(1)	—	11
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 914**	**$ 399**	**$ (215)**
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ 8.56	$ 3.80	$ (2.19)
Discontinued operations	$ (0.01)	$ —	$ 0.11
	$ 8.55	**$ 3.80**	**$ (2.08)**
Diluted			
Continuing operations	$ 8.43	$ 3.75	$ (2.19)
Discontinued operations	$ (0.01)	$ —	$ 0.11
	$ 8.42	**$ 3.75**	**$ (2.08)**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	106,833	105,010	103,398
Diluted	108,571	106,263	103,398

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2021	2020	2019
Net income	$ 1,476	$ 768	$ 171
Other comprehensive income (loss):			
Adjustments for defined benefit plans	50	(41)	(52)
Amortization of net actuarial loss included in other non-operating income (expense), net	11	9	10
Unrealized gain on debt securities held as available-for-sale	—	1	—
Foreign currency translation adjustments and other	1	—	—
Other comprehensive income (loss) before income taxes	**62**	**(31)**	**(42)**
Income tax benefit (expense) related to items of other comprehensive income (loss)	(14)	7	8
Total other comprehensive income (loss), net of tax	**48**	**(24)**	**(34)**
Comprehensive net income	**1,524**	**744**	**137**
Less: Comprehensive income to noncontrolling interests	**562**	**369**	**386**
Comprehensive income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 962**	**$ 375**	**$ (249)**

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		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balances at December 31, 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**
Net income	—	—	—	—	914	—	226	1,140
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(206)	(206)
Other comprehensive income	—	—	—	48	—	—	—	48
Accretion of redeemable noncontrolling interests	—	—	(11)	—	—	—	—	(11)
Purchases of businesses and noncontrolling interests, net	—	—	—	—	—	—	97	97
Stock-based compensation expense, tax benefit and issuance of common stock	1,119	1	44	—	—	4	—	49
Balances at December 31, 2021	**107,189**	**$ 8**	**$ 4,877**	**$ (233)**	**$ (1,214)**	**$ (2,410)**	**$ 1,026**	**$ 2,054**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2021	2020	2019
Net income	**$ 1,476**	**$ 768**	**$ 171**
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	855	857	850
Deferred income tax expense (benefit)	250	(128)	144
Stock-based compensation expense	56	44	42
Impairment and restructuring charges, and acquisition-related costs	85	290	185
Litigation and investigation costs	116	44	141
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(445)	(14)	15
Loss from early extinguishment of debt	74	316	227
Equity in earnings of unconsolidated affiliates, net of distributions received	(10)	(37)	(32)
Amortization of debt discount and debt issuance costs	33	38	35
Pre-tax loss (income) from discontinued operations	1	—	(15)
Other items, net	(33)	(29)	(15)
Changes in cash from operating assets and liabilities:			
Accounts receivable	(197)	195	(247)
Inventories and other current assets	(52)	(145)	(94)
Income taxes	68	19	8
Accounts payable, accrued expenses, contract liabilities and other current liabilities	(584)	1,302	12
Other long-term liabilities	28	221	3
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(153)**	**(333)**	**(192)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**—**	**(1)**	**(5)**
Net cash provided by operating activities	**1,568**	**3,407**	**1,233**
Cash flows from investing activities:			
Purchases of property and equipment	(658)	(540)	(670)
Purchases of businesses or joint venture interests, net of cash acquired	(1,220)	(1,177)	(25)
Proceeds from sales of facilities and other assets — continuing operations	1,248	77	63
Proceeds from sales of facilities and other assets — discontinued operations	—	—	17
Proceeds from sales of marketable securities, long-term investments and other assets	31	59	82
Purchases of marketable securities and equity investments	(108)	(44)	(62)
Other items, net	(7)	17	(24)
Net cash used in investing activities	**(714)**	**(1,608)**	**(619)**
Cash flows from financing activities:			
Repayments of borrowings under credit facility	—	(740)	(2,640)
Proceeds from borrowings under credit facility	—	740	2,640
Repayments of other borrowings	(3,221)	(3,293)	(6,131)
Proceeds from other borrowings	2,872	3,818	5,719
Debt issuance costs	(31)	(48)	(70)
Distributions paid to noncontrolling interests	(423)	(287)	(307)
Proceeds from sale of noncontrolling interests	25	14	21
Purchases of noncontrolling interests	(27)	(39)	(11)
Medicare advances and grants received by unconsolidated affiliates, net of recoupment	(67)	187	—
Other items, net	(64)	33	16
Net cash provided by (used in) financing activities	**(936)**	**385**	**(763)**
Net increase (decrease) in cash and cash equivalents	(82)	2,184	(149)
Cash and cash equivalents at beginning of period	2,446	262	411
Cash and cash equivalents at end of period	**$ 2,364**	**$ 2,446**	**$ 262**
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (937)	$ (962)	$ (946)
Income tax payments, net	$ (92)	$ (12)	$ (12)

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 our subsidiary USPI Holding Company, Inc. ("USPI"), at December 31, 2021, we operated 60 hospitals and 535 other healthcare facilities. We hold noncontrolling interests in 167 of these facilities, which are recorded using the equity method of accounting. At December 31, 2021, we held an ownership interest in USPI of approximately 95%. We also operate Conifer Health Solutions, LLC through our Conifer Holdings, Inc. subsidiary ("Conifer"). We owned an interest of approximately 76% in Conifer Health Solutions, LLC at December 31, 2021.

Our business consists of our Hospital Operations and other ("Hospital Operations") segment, our Ambulatory Care segment and our Conifer segment. Our Hospital Operations segment is comprised of our acute care and specialty hospitals, imaging centers, ancillary outpatient facilities, micro-hospitals and physician practices. Our Ambulatory Care segment is comprised of the operations of USPI, which holds ownership interests in ambulatory surgery centers and surgical hospitals. Our Conifer segment provides revenue cycle management and value-based care services to hospitals, health systems, physician practices, employers and other clients.

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. We also utilize the equity method when we have the ability to exercise significant influence over the affiliated company, despite not holding a significant percentage of its ownership interest. 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.

Certain prior-year amounts have been reclassified to conform to the current year presentation. In our consolidated balance sheets, income tax receivable has been reclassified to other current assets, as it is no longer significant enough to present separately. In our consolidated statements of cash flows, long-term assets has been combined with other items, net, as it is no longer significant enough to present separately, but it remains located within cash flows from investing activities. In addition, within the financing section of our statement of cash flows, proceeds from shares issued under stock-based compensation plans, net of taxes paid related to net share settlement has been combined with other items, net.

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.

COVID-19 Pandemic

During 2020 and 2021, COVID-19 impacted all three segments of our business, as well as our patients, communities and employees. Federal, state and local authorities undertook several actions in 2020 and 2021 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. Among other things, the legislative actions taken by the federal government to respond to the COVID-19 pandemic (collectively, the "COVID Acts") authorized aggregate grant payments of $178 billion to be distributed through the Public Health and Social Services Emergency Fund ("PRF") to health care providers who experienced lost revenues and increased expenses during the pandemic. The COVID Acts also revised the Medicare accelerated payment program to disburse payments to hospitals and other care providers more quickly and permitted employers to defer payment of the 6.2% employer Social Security tax beginning March 27, 2020 through December 31, 2020. Our participation in these programs and the related accounting policies are summarized below.

Grant Income—During the years ended December 31, 2021 and 2020, we received cash payments of $215 million and $974 million, including cash received by our unconsolidated affiliates, from the PRF and state and local grant programs. 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 the Secretary of HHS. In June 2021, HHS established new deadlines for when recipients of PRF grants must use the funding received, generally 12 to 18 months after receipt of the grant funds. HHS will recoup PRF grant funds not utilized by the established deadlines.

The table below summarizes grant funds received by our Hospital Operations and Ambulatory Care segments and by our unconsolidated affiliates for which we provide cash management services during the years ended December 31, 2021 and 2020, and their location in the accompanying Consolidated Statements of Cash Flows. There was no grant fund activity during the year ended December 31, 2019.

	Years Ended December 31,	
	2021	2020
Grant payments received from COVID-19 relief programs:		
Included in cash flows from operating activities:		
Hospital Operations	$ 142	$ 824
Ambulatory Care	36	76
	$ 178	$ 900
Included in cash flows from financing activities:		
Unconsolidated affiliates for which we provide cash management services	$ 37	$ 74

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 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.

The table below summarizes grant income recognized by our Hospital Operations and Ambulatory Care segments during the years ended December 31, 2021 and 2020. In addition, the table presents grant income recognized by our unconsolidated affiliates during 2021 and 2020, which is included in equity in earnings of unconsolidated affiliates in our consolidated statement of operations. No grant income was recognized during the year ended December 31, 2019.

	Years Ended December 31,	
	2021	2020
Grant income recognized from COVID-19 relief programs:		
Included in grant income:		
Hospital Operations	$ 142	$ 823
Ambulatory Care	49	59
	$ 191	$ 882
Included in equity in earnings of unconsolidated affiliates:		
Unconsolidated affiliates	$ 14	$ 17

At December 31, 2021 and 2020, we had remaining deferred grant payment balances of $5 million and $18 million, respectively, which amounts were recorded in other current liabilities in the accompanying Consolidated Balance Sheets for those periods.

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 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 is 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 unrecouped balance will be assessed at 4.00% per annum. The initial 11-month recoupment period began in April 2021.

Our Hospital Operations and Ambulatory Care segments both received advance payments from the Medicare accelerated payment program during 2020. No additional advances were received in the year ended December 31, 2021. During the year ended December 31, 2021, $457 million of advances received by our Hospital Operations segment and $36 million of advances received by our Ambulatory Care segment were recouped through a reduction of our Medicare claims payments. Also in 2021, $40 million of advances received by our unconsolidated affiliates for which we provide cash management services were recouped through a reduction of those affiliates' Medicare claims payments. In addition to the amounts recouped during the year ended December 31, 2021, our Ambulatory Care segment repaid $83 million of advances, including $64 million for advances received by our unconsolidated affiliates for which we provide cash management services. In the accompanying Consolidated Balance Sheets, advances totaling $880 million and $603 million were included in contract liabilities at December 31, 2021 and December 31, 2020, respectively, and advances totaling $902 million were included in contract liabilities – long term 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. We remitted the first portion of the deferred Social Security tax payments in December 2021. At December 31, 2021, deferred Social Security tax payments totaling $128 million were included in accrued compensation and benefits in the accompanying Consolidated Balance Sheets.

Translation of Foreign Currencies

We formed our Global Business Center ("GBC") in the Philippines during the year ended December 31, 2019. The GBC's accounts are measured in its local currency (the Philippine peso) 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, individual hospitals and physician practices.

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 Eligibility and Enrollment Services 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. For contracts in which the amortization period of the asset is one year or less, we have elected to apply the practical expedient provided by FASB ASC 340-40-25-4 and expense these costs as incurred.

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 $2.364 billion and $2.446 billion at December 31, 2021 and 2020, respectively. At December 31, 2021 and 2020, our book overdrafts were $226 million and $154 million, respectively, which were classified as accounts payable. At December 31, 2021 and 2020, $188 million and $166 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our insurance-related subsidiaries.

At December 31, 2021, 2020 and 2019, we had $95 million, $93 million and $136 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $88 million, $85 million and $119 million, respectively, were included in accounts payable.

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, 2021, 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 257 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 (166 of 423 at December 31, 2021), 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 years ended December 31, 2021 and 2020, equity in earnings of unconsolidated affiliates included $14 million and $17 million, respectively, 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. 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,		
	2021	2020	2019
Current assets	$ 1,176	$ 1,309	$ 1,180
Noncurrent assets	$ 1,390	$ 1,262	$ 1,042
Current liabilities	$ (495)	$ (516)	$ (372)
Noncurrent liabilities	$ (855)	$ (866)	$ (739)
Noncontrolling interests	$ (659)	$ (621)	$ (579)

	Years Ended December 31,		
	2021	2020	2019
Net operating revenues	$ 3,030	$ 2,665	$ 2,680
Net income	$ 836	$ 702	$ 765
Net income attributable to the investees	$ 499	$ 437	$ 499

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 $107 million, $85 million and $79 million of total equity in earnings of unconsolidated affiliates of $218 million, $169 million and $175 million in the years ended December 31, 2021, 2020 and 2019, respectively.

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, 2021, 2020 and 2019, capitalized interest was $4 million, $5 million and $11 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 charge only if the carrying value of the long-lived assets exceeds their fair value. The fair value of the asset 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. Estimates require our subjective judgments and take into account assumptions about revenue and expense growth rates, operating margins and recoverable disposition values, based on industry and operating factors. These assumptions may vary by type of asset and presume stable, improving or, in some cases, declining results, 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.

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 the 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.

G***oodwill 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.

Accruals for General and Professional Liability Risks

We accrue for estimated professional and general liability claims, when they are probable and can be reasonably estimated. The accrual, which includes an estimate of 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.

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 80% of our net operating revenues in the year ended December 31, 2021 and 81% during both of the years ended December 31, 2020 and 2019. At December 31, 2021, each of our markets related to our general hospitals reported directly to our chief executive officer. Major decisions, including capital resource allocations, are made at the consolidated level, not at the market or hospital level. 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.

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. NONCONTROLLING INTERESTS

Our noncontrolling interests balances at December 31, 2021 and 2020 in the accompanying Consolidated Statements of Changes in Equity were comprised of $128 million and $116 million, respectively, from our Hospital Operations segment, and $898 million and $793 million, respectively, from our Ambulatory Care segment. Our net income attributable to noncontrolling interests for the years ended December 31, 2021, 2020 and 2019 were comprised of $21 million, $14 million and $16 million, respectively, from our Hospital Operations segment, and $205 million, $169 million and $178 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,	
	2021	**2020**
Continuing operations:		
Patient accounts receivable	$ 2,600	$ 2,499
Estimated future recoveries	137	156
Net cost reports and settlements receivable and valuation allowances	33	34
	2,770	2,689
Discontinued operations	—	1
Accounts receivable, net	**$ 2,770**	**$ 2,690**

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.

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 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.

We participate in various provider fee programs, which help reduce the amount of uncompensated care from indigent patients and those paying with Medicaid. 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:

	December 31,	
	2021	2020
Assets:		
Other current assets	$ 370	$ 378
Investments and other assets	$ 213	$ 206
Liabilities:		
Other current liabilities	$ 123	$ 110
Other long-term liabilities	$ 60	$ 56

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 now-divested health plan businesses) of caring for our uninsured and charity patients:

	Years Ended December 31,		
	2021	2020	2019
Estimated costs for:			
Uninsured patients	$ 650	$ 617	$ 664
Charity care patients	97	147	156
Total	$ 747	$ 764	$ 820

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 were included in other current assets in the accompanying Consolidated Balance Sheets at December 31, 2021 and 2020. Approximately 91% 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 to disburse payments more quickly. During the year ended December 31, 2020, our Hospital Operations segment received advance payments from the Medicare accelerated payment program following its expansion under the COVID Acts. No additional advances were received during the year ended December 31, 2021. The advance payments received were recorded as contract liabilities in the accompanying Consolidated Balance Sheets at December 31, 2021 and 2020.

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

	Contract Assets	Contract Liability – Current Advances from Medicare	Contract Liability – Long-term Advances from Medicare
December 31, 2020	$ 208	$ 510	$ 819
December 31, 2021	181	876	—
Increase (decrease)	**$ (27)**	**$ 366**	**$ (819)**
December 31, 2019	$ 170	$ —	$ —
December 31, 2020	208	510	819
Increase	**$ 38**	**$ 510**	**$ 819**

Ambulatory Care Segment

During the year ended December 31, 2020, our Ambulatory Care segment also received advance payments from the Medicare accelerated payment program. In addition to the advances received by our Ambulatory Care segment, contract liabilities and contract liabilities – long-term in the accompanying Consolidated Balance Sheet included $51 million and $62 million, respectively, of Medicare advance payments received by our unconsolidated affiliates for which we provide cash management services at December 31, 2020.

The opening and closing balances of contract liabilities for our Ambulatory Care segment were as follows:

	Contract Liability – Current Advances from Medicare	Contract Liability – Long-term Advances from Medicare
December 31, 2020	$ 93	$ 83
December 31, 2021	4	—
Decrease	**$ (89)**	**$ (83)**
December 31, 2019	$ —	$ —
December 31, 2020	93	83
Increase	**$ 93**	**$ 83**

Conifer Segment

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

	Receivables	Contract Asset – Unbilled Revenue	Contract Liability – Current Deferred Revenue	Contract Liability – Long-Term Deferred Revenue
December 31, 2020	$ 56	$ 20	$ 56	$ 16
December 31, 2021	28	18	79	15
Increase (decrease)	**$ (28)**	**$ (2)**	**$ 23**	**$ (1)**
December 31, 2019	$ 26	$ 11	$ 61	$ 18
December 31, 2020	56	20	56	16
Increase (decrease)	**$ 30**	**$ 9**	**$ (5)**	**$ (2)**

The differences 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 were reported as part of other current assets in the accompanying Consolidated Balance Sheets, and its current and long-term contract liabilities were reported as part of contract liabilities and contract liabilities – long-term, respectively, in the accompanying Consolidated Balance Sheets.

In the years ended December 31, 2021 and 2020, Conifer recognized $56 million and $61 million, respectively, 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 recognized amortization expense related to deferred contract setup costs of $4 million in both of the years ended December 31, 2021 and 2020, and $5 million in the year ended December 31, 2019. At December 31, 2021 and 2020, the unamortized customer contract costs were $23 million and $24 million, respectively, and were presented as part of investments and other assets in the accompanying Consolidated Balance Sheets.

NOTE 5. ASSETS AND LIABILITIES HELD FOR SALE

In August 2021, we completed the sale of five Miami-area hospitals and certain related operations (the "Miami Hospitals") held by our Hospital Operations segment. We recognized a pre-tax gain on sale of $406 million during the year ended December 31, 2021, which was included in net losses (gains) on sales, consolidation and deconsolidation of facilities in the accompanying Consolidated Statement of Operations.

In the three months ended June 30, 2021, we completed the sale of the majority of our urgent care centers operated under the MedPost and CareSpot brands by our Hospital Operations and Ambulatory Care segments. During the same period, we also completed the sale of a building we owned in the Philadelphia area that was held by our Hospital Operations segment. The assets and liabilities related to the urgent care centers and the building were classified as held for sale at December 31, 2020 in the accompanying Consolidated Balance Sheet. We recorded pre-tax gains of $14 million and $2 million related to the sale of the urgent care centers and the sale of the building in Philadelphia, respectively, in the year ended December 31, 2021.

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 in December 2020 and reclassified as held and used in our consolidated balance sheet.

In the first quarter of 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 fourth quarter of 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.

Gains and losses related to the sales described above were included in net losses (gains) on sales, consolidation and deconsolidation of facilities in the accompanying Consolidated Statements of Operations in the respective years in which they were realized.

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 years ended December 31, 2021 and 2020 related to planned divestitures.

The following table provides information on significant components of our business that were recently disposed of:

	Years Ended December 31,		
	2021	2020	2019
Significant disposals:			
Income (loss) from continuing operations, before income taxes:			
Chicago-area hospitals (includes a $5 million loss on sale in the 2020 period and a $14 million loss on sale in the 2019 period)	$ (2)	$ 3	$ (19)
Miami Hospitals (includes a $406 million gain on sale in 2021)	455	67	44
Total	**$ 453**	**$ 70**	**$ 25**

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

We recognized impairment charges on long-lived assets in 2021, 2020 and 2019 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 marketplace 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 each facility's 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.

At December 31, 2021, 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, 2021.

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. Certain restructuring and acquisition-related costs are based on estimates. Changes in estimates are recognized as they occur.

Year Ended December 31, 2021

During the year ended December 31, 2021, we recorded impairment and restructuring charges and acquisition-related costs of $85 million, consisting of $57 million of restructuring charges, $8 million of impairment charges and $20 million of acquisition-related costs. Restructuring charges consisted of $14 million of employee severance costs, $19 million related to the transition of various administrative functions to our GBC and $24 million of other restructuring costs. Impairments primarily consisted of charges to reduce the carrying value of certain management contract intangible assets held by our Ambulatory Care segment to their estimated fair value. Our impairment charges for the year ended December 31, 2021 were comprised of $5 million from our Ambulatory Care segment and $3 million from our Conifer segment. Acquisition-related costs consisted of $20 million of transaction costs.

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 included $76 million for the write-down of hospital buildings to their estimated fair values, which assets are part of our Hospital Operations segment. Material adverse trends in our 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.

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 Sheets at:

Component of Lease Balances	Classification in Consolidated Balance Sheet	December 31, 2021	December 31, 2020
Assets:			
Operating lease assets	Investments and other assets	$ 1,002	$ 1,062
Finance lease assets	Property and equipment, at cost, less accumulated depreciation and amortization	333	345
Total leased assets		**$ 1,335**	**$ 1,407**
Liabilities:			
Operating lease liabilities:			
Current	Other current liabilities	$ 201	$ 188
Long-term	Other long-term liabilities	924	999
Total operating lease liabilities		1,125	1,187
Finance lease liabilities:			
Current	Current portion of long-term debt	106	122
Long-term	Long-term debt, net of current portion	176	151
Total finance lease liabilities		282	273
Total lease liabilities		**$ 1,407**	**$ 1,460**

The following table presents the components of our lease expense and their classification in our Consolidated Statements of Operations:

Component of Lease Expense	Classification in Consolidated Statements of Operations	Years Ended December 31, 2021	2020	2019
Operating lease expense	Other operating expenses, net	$ 241	$ 247	$ 211
Finance lease expense:				
Amortization of leased assets	Depreciation and amortization	71	86	85
Interest on lease liabilities	Interest expense	9	11	15
Total finance lease expense		80	97	100
Variable and short term-lease expense	Other operating expenses, net	171	156	133
Total lease expense		**$ 492**	**$ 500**	**$ 444**

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

	Years Ended December 31, 2021	2020	2019
Weighted-average remaining lease term (years):			
Operating leases	7.5	7.9	7.8
Finance leases	5.7	5.7	5.4
Weighted-average discount rate:			
Operating leases	5.1 %	5.5 %	5.6 %
Finance leases	5.4 %	5.6 %	5.5 %

Cash flow and other information related to leases is included in the following table:

	Years Ended December 31,		
	2021	2020	2019
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash outflows from operating leases	$ 237	$ 239	$ 197
Operating cash outflows from finance leases	$ 12	$ 15	$ 18
Financing cash outflows from finance leases	$ 140	$ 154	$ 151
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	$ 176	$ 304	$ 249
Finance leases	$ 136	$ 98	$ 141

Future maturities of lease liabilities at December 31, 2021 are presented in the following table:

	Operating Leases	Finance Leases	Total
2022	$ 236	$ 116	$ 352
2023	211	76	287
2024	185	48	233
2025	156	16	172
2026	124	11	135
Later years	456	83	539
Total lease payments	1,368	350	1,718
Less: Imputed interest	243	68	311
Total lease obligations	1,125	282	1,407
Less: Current obligations	201	106	307
Long-term lease obligations	**$ 924**	**$ 176**	**$ 1,100**

NOTE 8. LONG-TERM DEBT

The table below shows our long-term debt included in the accompanying Consolidated Balance Sheets:

	December 31,	
	2021	2020
Senior unsecured notes:		
6.750% due 2023	$ 1,872	$ 1,872
7.000% due 2025	—	478
6.125% due 2028	2,500	2,500
6.875% due 2031	362	362
Senior secured first lien notes:		
4.625% due 2024	770	1,870
4.625% due 2024	600	600
7.500% due 2025	700	700
4.875% due 2026	2,100	2,100
5.125% due 2027	1,500	1,500
4.625% due 2028	600	600
4.250% due 2029	1,400	—
4.375% due 2030	1,450	—
Senior secured second lien notes:		
5.125% due 2025	—	1,410
6.250% due 2027	1,500	1,500
Finance leases, mortgage and other notes	443	403
Unamortized issue costs and note discounts	(151)	(176)
Total long-term debt	**15,646**	**15,719**
Less current portion	135	145
Long-term debt, net of current portion	**$ 15,511**	**$ 15,574**

Credit Agreement

We have a senior secured revolving credit facility that provides for revolving loans in an aggregate principal amount of up to $1.900 billion with a $200 million subfacility for standby letters of credit. We amended our credit agreement (as amended to date, the "Credit Agreement") in April 2020 to, among other things, (i) increase the aggregate revolving credit commitments from the previous limit of $1.500 billion to $1.900 billion (the "Increased Commitments"), 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 April 2021, we further amended the Credit Agreement to, among other things, extend the availability of the Increased Commitments through April 22, 2022 and reduce the interest rate margins. At December 31, 2021, 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, $1.797 billion was available for borrowing at December 31, 2021.

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 accrue interest depending on the type of loan at either (i) a base rate plus a margin ranging from 0.25% to 0.75% per annum, or (ii) the Euro Interbank Offered Rate plus a margin ranging from 1.25% to 1.75% per annum, in each case based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.25% to 0.375% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible inventory and accounts receivable, including self-pay accounts.

Letter of Credit Facility

We have a letter of credit facility that provides for the issuance of standby and documentary letters of credit. 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 incrementally increase the maximum secured debt covenant from 4.25 to 1.00 on a quarterly basis up to 6.00 to 1.00 for the quarter ended March 31, 2021, at which point the maximum ratio began to step down incrementally on a quarterly basis through the quarter ended December 31, 2021. At December 31, 2021, the effective maximum secured debt covenant was 4.25 to 1.00, where it will remain until maturity. 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, 2021, we had $139 million of standby letters of credit outstanding under the LC Facility and were in compliance with all applicable covenants and conditions.

Senior Secured Notes and Senior Unsecured Notes

On December 1, 2021, we issued $1.450 billion aggregate principal amount of 4.375% senior secured first lien notes, which will mature on January 15, 2030 (the "2030 Senior Secured First Lien Notes"). We will pay interest on the 2030 Senior Secured First Lien Notes semi-annually in arrears on January 15 and July 15 of each year, commencing on July 15, 2022. We used the net proceeds from the issuance of the 2030 Senior Secured First Lien Notes, after payment of fees and expenses, to finance the acquisition of the SCD Centers in December 2021 and for general corporate purposes.

On September 10, 2021, we redeemed approximately $1.100 billion of the then-outstanding $1.870 billion aggregate principal amount of our 4.625% senior secured first lien notes due 2024 in advance of their maturity date. We paid $1.113 billion to redeem the notes, which was primarily funded with the proceeds from the sale of the Miami Hospitals in August 2021. In connection with the redemption, we recorded a loss from early extinguishment of debt of $20 million in the three months ended September 30, 2021, primarily related to the difference between the purchase price and the par value of the notes, as well as the write-off of associated unamortized issuance costs.

On June 2, 2021, we issued $1.400 billion aggregate principal amount of 4.250% senior secured first lien notes, which will mature on June 1, 2029 (the "2029 Senior Secured First Lien Notes"). We pay interest on the 2029 Senior Secured First Lien Notes semi-annually in arrears on June 1 and December 1 of each year, which payments commenced on December 1, 2021. The proceeds from the sale of the 2029 Senior Secured First Lien Notes were used, after payment of fees and expenses, together with cash on hand, to finance the redemption of all $1.410 billion aggregate principal amount then outstanding of our 5.125% senior secured second lien notes due 2025 (the "2025 Senior Secured Second Lien Notes") in advance of their maturity date for approximately $1.428 billion. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $31 million in the three months ended June 30, 2021, primarily related to the difference between the purchase price and the par value of the 2025 Senior Secured Second Lien Notes, as well as the write-off of associated unamortized issuance costs.

In March 2021, we retired all $478 million aggregate principal amount outstanding of our 7.000% senior unsecured notes due 2025 in advance of their maturity date. We paid approximately $495 million from cash on hand to retire the notes. In connection with the retirement, we recorded a loss from early extinguishment of debt of $23 million in the three months ended March 31, 2021, primarily related to the difference between the purchase price and the par value of the notes, as well as the write-off of associated unamortized issuance costs.

In September 2020, we sold $2.500 billion aggregate principal amount of 6.125% senior notes, which will mature on October 1, 2028 (the "2028 Senior Notes"). We pay interest on the 2028 Senior Notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced 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.

Through a series of transactions during June, July and August 2020, we purchased approximately $244 million aggregate principal amount of our 2022 Senior Notes for approximately $256 million. In connection with the purchases, we recorded a loss from early extinguishment of debt totaling $15 million in the year ended December 31, 2020, primarily related to the differences between the purchase prices and the par values of the 2022 Senior Notes, as well as the write-off of associated unamortized issuance costs.

In June 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 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.

In April 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 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.

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 were as follows as of December 31, 2021:

		Years Ending December 31,					
	Total	2022	2023	2024	2025	2026	Later Years
Long-term debt, including finance lease obligations	$ 15,797	$ 135	$ 1,983	$ 1,446	$ 742	$ 2,120	$ 9,371

As discussed in Note 25, in February 2022, we announced the redemption of all $700 million aggregate principal amount outstanding of our 2025 Senior Secured First Lien Notes. These notes are included in the table above based on their stated maturity date.

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, 2021, 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 $122 million. We had a total liability of $104 million recorded for these guarantees included in other current liabilities in the accompanying Consolidated Balance Sheet at December 31, 2021.

At December 31, 2021, 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 $94 million. Of the total, $12 million relates to the obligations of consolidated subsidiaries, which obligations were recorded in the accompanying Consolidated Balance Sheet at December 31, 2021.

NOTE 10. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

We have granted stock options and restricted stock units (“RSUs”) to certain of our employees and directors pursuant to our stock incentive plans. Stock 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. An RSU is a contractual right to receive one share of our common stock in the future, and the fair value of the RSU is based on our share price on the grant date. Typically, stock options and time-based RSUs 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, grants of RSUs 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 stock options and performance-based RSUs that vest subject to the achievement of specified performance goals within a specified time frame. The performance-based RSUs may contain provisions that increase or decrease the number of RSUs that ultimately vest, depending upon the level of achievement. For certain of our performance-based awards, the number of options or RSUs that ultimately vest is also subject to adjustment based on the achievement of a market-based condition. These adjustments generally range from 0% to 200% of the number of RSUs initially granted. The fair value of awards that contain a market-based condition 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.

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.

At December 31, 2021, assuming outstanding performance-based stock options and RSUs for which performance has not yet been determined will achieve target performance, approximately 5.3 million shares of common stock were available under our 2019 Stock Incentive Plan for future stock option grants and other equity incentive awards, including RSUs. The accompanying Consolidated Statements of Operations for the years ended December 31, 2021, 2020 and 2019 include $56 million, $44 million and $42 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements.

The table below shows certain stock option and RSU grants and other awards, net of forfeitures, that comprise the stock-based compensation expense recorded in the year ended December 31, 2021. 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, 2021
	(In Thousands)			(In Millions)
Stock options:				
February 27, 2019	188	$ 28.26	$ 12.49	$ 1
Restricted stock units:				
May 7, 2021	37		$ 47.99	2
February 24, 2021	585		$ 52.85	12
February 26, 2020	1,221		$ 27.80	15
February 27, 2019	790		$ 28.26	5
January 31, 2019	318		$ 21.99	2
Other grants(1)	661		$ 30.73	6
Other stock-based compensation plans:				
USPI management equity plan	1,883		$ 34.13	13
				$ 56

(1) Per-share value presented is the weighted-average grant date fair value of the grants included. Grant dates range from June 2016 to September 2021 with per-share grant date fair values ranging from $18.11 to $74.99.

Stock Options

The following table summarizes stock option activity during the years ended December 31, 2021, 2020 and 2019:

	Options	Wtd. Avg. Exercise Price Per Share	Aggregate Intrinsic Value	Wtd. Avg Remaining Life
			(In Millions)	
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		
Exercised	(391,533)	$ 20.66		
Outstanding at December 31, 2021	**520,998**	**$ 23.90**	**$ 30**	**6.2 years**
Vested and expected to vest at December 31, 2021	**520,998**	**$ 23.90**	**$ 30**	**6.2 years**
Exercisable at December 31, 2021	**324,980**	**$ 21.25**	**$ 20**	**5.7 years**

No stock options were granted during the years ended December 31, 2021 and 2020. There were 391,533 stock options exercised during the year ended December 31, 2021 with an aggregated intrinsic value of approximately $15 million, and 987,471 stock options exercised in 2020 with an aggregate intrinsic value of approximately $15 million.

The following table summarizes information about our outstanding stock options at December 31, 2021:

	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
$18.99 to $20.609	293,796	5.6 years	$ 19.75	293,796	$ 19.75
$20.61 to $35.430	227,202	6.9 years	29.26	31,184	35.43
	520,998	**6.2 years**	**$ 23.90**	**324,980**	**$ 21.25**

As of December 31, 2021, 57.0% of all our outstanding options were held by current employees and 43.0% were held by former employees. Of our outstanding options, 100% were in-the-money, that is, they had exercise price less than the $81.69 market price of our common stock on December 31, 2021.

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	296,916	57.0 %	—	— %	296,916	57.0 %
Former employees	224,082	43.0 %	—	— %	224,082	43.0 %
Totals	**520,998**	**100.0 %**	**—**	**—**	**520,998**	**100.0 %**
% of all outstanding options	**100.0 %**		**— %**		**100.0 %**	

Restricted Stock Units

The following table summarizes RSU activity during the years ended December 31, 2021, 2020 and 2019:

	Restricted Stock Units	Wtd. Avg. Grant Date Fair Value Per Unit
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
Granted	900,018	$ 58.61
Vested	(765,814)	$ 30.51
Forfeited	(58,208)	$ 37.60
Unvested at December 31, 2021	**2,171,202**	**$ 40.51**

During the year ended December 31, 2021 we granted 561,788 RSUs that vest based on the passage of time. The granted RSUs vest as follows:

- 263,180 RSUs vest and settle ratably over a three-year period from the grant date;
- 189,215 RSUs vest and settle ratably over eight quarterly periods from the grant date;
- 53,341 RSUs vest and settle on the fourth anniversary of the grant date;
- 33,351 RSUs vest and settle on the third anniversary of the grant date;
- 14,192 RSUs vested on December 31, 2021 and settled in January 2022; and
- 8,509 RSUs, one-third of which vest and settle on the second anniversary of the grant date and the remainder of which vest and settle on the fourth anniversary.

During the year ended December 31, 2021 we granted 298,492 performance-based RSUs which vest as follows:

- 244,259 RSUs vest and settle on the third anniversary of the grant date, contingent upon the achievement of performance goals for the years 2021 to 2023;
- 53,341 RSUs vest and settle on the fourth anniversary of the grant date, contingent upon the achievement of performance goals for the years 2021 to 2025; and
- 892 RSUs vested and settled immediately as a result of our level of achievement with respect to performance-based RSUs granted in 2018.

The actual number of performance-based RSUs that could vest will range from 0% to 200% of the 297,600 unvested RSUs granted, depending upon our level of achievement with respect to the performance goals.

During the year ended December 31, 2021, we also granted 39,738 RSUs to our non-employee directors. These consisted of 36,681 RSUs for the 2021-2022 board service year, 1,372 for an initial grant to a new member of our board of directors and 1,685 for a pro-rata annual grant to the same new member. While RSUs granted to our board of directors vest immediately, annual grants settle on the third anniversary of the grant date and initial grants settle upon separation from the board.

During the year ended December 31, 2020 we granted 1,084,883 RSUs that vest based on the passage of time. The granted RSUs vest as follows:

- 607,198 RSUs vest and settle ratably over a three-year period from the grant date;
- 359,713 RSUs vest and settle ratably over 11 quarterly periods from the grant date;
- 104,167 RSUs vest and settle ratably over a four-year period from the grant date; and
- 13,805 RSUs vest and settle on the third anniversary of the grant date.

During the year ended December 31, 2020 we granted 579,413 performance-based RSUs which vest as follows:

- 499,285 RSUs vest and settle on the third anniversary of the grant date, contingent upon the achievement of performance goals for the years 2020 to 2022 and
- 80,128 RSUs vest and settle on the fourth anniversary of the grant date, contingent upon the achievement of performance goals for the years 2020 to 2023, all of which were subsequently forfeited.

The actual number of performance-based RSUs that could vest will range from 0% to 200% of the 499,285 remaining RSUs granted, depending upon our level of achievement with respect to the performance goals.

In May 2020, we made an annual grant of 103,434 RSUs to our non-employee directors for the 2020-2021 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.

As of December 31, 2021, there were $47 million of total unrecognized compensation costs related to RSUs. These costs are expected to be recognized over a weighted average period of 1.7 years.

For certain of the performance-based RSU grants, the number of units that will ultimately vest is subject to adjustment based on the achievement of a market-based condition. The fair value of these RSUs is estimated through the use of a Monte Carlo simulation. Significant inputs used in our valuation of these RSUs included the following:

	Years Ended December 31,	
	2021	2020
Expected volatility	65.2% - 79.3%	54.7 %
Risk-free interest rate	0.1% - 0.6%	1.2 %

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. Under the 2020 USPI Management Equity Plan, USPI grants RSUs representing a contractual right to receive one share of USPI's non-voting common stock in the future. The vesting of RSUs granted under the plan varies based on the terms of the underlying award agreement. 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.

The following table summarizes RSU activity under USPI's management equity plan during the year ended December 31, 2021 and 2020:

	Number of Restricted Stock Units		Wtd. Avg. Grant Date Fair Value Per Unit
Inception of Plan			
Granted	2,556,353	$	34.13
Forfeited	(531,297)	$	34.13
Unvested at December 31, 2020	2,025,056	$	34.13
Granted	76,990	$	34.13
Vested	(388,588)	$	34.13
Forfeited	(218,576)	$	34.13
Unvested at December 31, 2021	**1,494,882**	**$**	**34.13**

During the year ended December 31, 2021, USPI granted 76,990 RSUs under its management equity plan. Twenty percent of these RSUs vests on each of the first and second anniversaries of the grant date, and the remaining 60% vests on the third anniversary of the grant date. In 2020, USPI granted 2,556,333 RSUs, 20% of which vest 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.

During the year ended December 31, 2021, USPI paid $9.0 million to repurchase a portion of the non-voting common stock issued under the USPI management equity plan. No shares were repurchased through the issuance of Tenet common stock during the year ended December 31, 2021.

At December 31, 2021, 1,494,882 RSUs were outstanding under USPI's management equity plan, all of which are expected to vest. The accompanying Consolidated Statements of Operations for the years ended December 31, 2021, 2020 and 2019 included $13 million, $12 million and $11 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, 2021, there were approximately 2.7 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:

	Years Ended December 31,		
	2021	2020	2019
Number of shares	89,865	254,767	215,422
Weighted average price	$ 63.01	$ 19.97	$ 24.44

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 $98 million, $119 million and $127 million for the years ended December 31, 2021, 2020 and 2019, 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, 2021 and 2020, the Society of Actuaries issued new mortality improvement scales (MP-2021 and MP-2020, respectively), which we incorporated into the estimates of our defined benefit plan obligations at December 31, 2021 and 2020. These changes to our mortality assumptions increased our projected benefit obligations as of December 31, 2021 by approximately $5 million and decreased our projected benefit obligations as of December 31, 2020 by approximately $39 million.

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:

	December 31,	
	2021	2020
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations[1]		
Beginning obligations	$ (1,429)	$ (1,369)
Interest cost	(36)	(47)
Actuarial gain (loss)	42	(92)
Benefits paid	110	79
Ending obligations	(1,313)	(1,429)
Fair value of plans assets		
Beginning plan assets	869	790
Gain on plan assets	62	98
Employer contribution	22	38
Benefits paid	(86)	(57)
Ending plan assets	867	869
Funded status of plans	$ (446)	$ (560)

(1) The accumulated benefit obligation at December 31, 2021 and 2020 was approximately $1.311 billion and $1.426 billion, respectively.

	December 31,	
	2021	2020
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (25)	$ (63)
Other long-term liability	$ (421)	$ (497)
Accumulated other comprehensive loss	$ 294	$ 355
SERP Assumptions:		
Discount rate	3.00 %	2.75 %
Compensation increase rate	3.00 %	3.00 %
Measurement date	December 31, 2021	December 31, 2020
DMC Pension Plan Assumptions:		
Discount rate	2.89 %	2.53 %
Compensation increase rate	Frozen	Frozen
Measurement date	December 31, 2021	December 31, 2020

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

	Years Ended December 31,		
	2021	2020	2019
Interest costs	$ 36	$ 47	$ 58
Expected return on plan assets	(53)	(48)	(46)
Amortization of net actuarial loss	11	9	10
Special termination benefit costs	—	—	1
Net periodic benefit cost (income)	$ (6)	$ 8	$ 23
SERP Assumptions:			
Discount rate	2.75 %	3.50 %	4.50 %
Compensation increase rate	3.00 %	3.00 %	3.00 %
Measurement date	January 1, 2021	January 1, 2020	January 1, 2019
Census date	January 1, 2021	January 1, 2020	January 1, 2019
DMC Pension Plan Assumptions:			
Discount rate	2.53 %	3.60 %	4.62 %
Long-term rate of return on assets	6.25 %	6.25 %	6.50 %
Compensation increase rate	Frozen	Frozen	Frozen
Measurement date	January 1, 2021	January 1, 2020	January 1, 2019
Census date	January 1, 2021	January 1, 2020	January 1, 2019

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 gain (loss) adjustments of $61 million, $(32) million and $(42) million in other comprehensive income in the years ended December 31, 2021, 2020 and 2019, 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 gains (losses) of $50 million, $(41) million and $(52) million were recognized during the years ended December 31, 2021, 2020 and 2019, respectively, and the amortization of net actuarial loss of $11 million, $9 million and $10 million for the years ended December 31, 2021, 2020 and 2019, respectively, were recognized in other comprehensive income. Actuarial gain (loss) affecting the benefit obligation during the years ended December 31, 2021, 2020 and 2019 are primarily attributable to changes in the discount rate utilized for the SERP and DMC Pension Plan. Cumulative net actuarial losses of $294 million, $355 million and $323 million as of December 31, 2021, 2020 and 2019, respectively. There were no unrecognized prior service costs at December 31, 2021 and 2020, and unrecognized prior service costs of less than $1 million at December 31, 2019 that had not yet been recognized as components of net periodic benefit cost.

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, 2021, were as follows:

Asset Category	Target	Actual
Cash and cash equivalents	— %	1 %
Equity securities	32 %	28 %
Debt securities	58 %	59 %
Alternative investments	11 %	11 %

The DMC Pension Plan assets are invested in public commingled vehicles, segregated separately managed accounts, and private commingled vehicles, all of which are managed by professional 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 cash and cash equivalents, including but not limited to money market funds and repurchase agreements secured by U.S. Treasury or federal agency obligations, equity securities, including but not limited to the publicly traded shares of U.S. companies with

various market capitalizations in addition to international and convertible securities, debt securities including, but not limited to, domestic and foreign government obligations, corporate bonds, and mortgage-backed securities, and alternative investments. Alternative investments is a broadly defined asset category with the objective of diversifying the overall 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 hedge funds in the form of professionally managed pooled limited partnership investments and investments in private markets via professionally managed pooled limited partnership interests.

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 within each asset class allowing for deviation within the established range for each asset class. The portfolio is rebalanced on an as-needed basis to keep these allocations within the accepted ranges.

The following tables summarize the DMC Pension Plan assets measured at fair value on a recurring basis as of December 31, 2021 and 2020, 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, 2021	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 11	$ 11	$ —	$ —
Equity securities	242	242	—	—
Debt Securities:				
U.S. government obligations	67	67	—	—
Corporate debt securities	448	448	—	—
Alternative investments:				
Private equity securities	57	—	—	57
Real estate securities	16	16	—	—
Hedge funds	26	—	—	26
	$ 867	$ 784	$ —	$ 83

	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

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,					
	Total	2022	2023	2024	2025	2026	Five Years Thereafter
Estimated benefit payments	$ 828	$ 83	$ 84	$ 85	$ 85	$ 85	$ 406

The SERP and DMC Pension Plan obligations of $446 million at December 31, 2021 are classified in the accompanying Consolidated Balance Sheet as an other current liability of $25 million and defined benefit plan obligations of $421 million based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately $25 million for the year ending December 31, 2022.

NOTE 11. PROPERTY AND EQUIPMENT

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

	December 31,	
	2021	2020
Land	$ 635	$ 612
Buildings and improvements	6,652	6,985
Construction in progress	166	33
Equipment	4,455	4,593
Finance lease assets	479	512
	12,387	12,735
Accumulated depreciation and amortization	(5,960)	(6,043)
Net property and equipment	**$ 6,427**	**$ 6,692**

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 was included in the accompanying Consolidated Balance Sheets:

	December 31,	
	2021	2020
Hospital Operations		
Goodwill at beginning of period:		
Goodwill	$ 5,375	$ 5,338
Accumulated impairment losses	(2,430)	(2,430)
	2,945	2,908
Goodwill transferred from Ambulatory Care segment	41	—
Goodwill related to assets held for sale and disposed	(178)	37
Goodwill at end of period	**$ 2,808**	**$ 2,945**
Goodwill at end of period:		
Goodwill	$ 5,238	$ 5,375
Accumulated impairment losses	(2,430)	(2,430)
Goodwill at end of period	**$ 2,808**	**$ 2,945**
Ambulatory Care		
Goodwill at beginning of period	$ 5,258	$ 3,739
Goodwill acquired during the year and purchase price allocation adjustments	664	1,581
Goodwill transferred to Hospital Operations segment	(41)	—
Goodwill related to assets held for sale and disposed or deconsolidated facilities	(33)	(62)
Goodwill at end of period	**$ 5,848**	**$ 5,258**
Conifer		
Goodwill at beginning of period	$ 605	$ 605
Goodwill acquired during the year and purchase price allocation adjustments	—	—
Goodwill related to assets held for sale and disposed or deconsolidated facilities	—	—
Goodwill at end of period	**$ 605**	**$ 605**

There were no accumulated impairment losses related to the goodwill in our Ambulatory Care and Conifer segments at December 31, 2021 and 2020.

The following table provides information regarding other intangible assets, which were included in the accompanying Consolidated Balance Sheets as of December 31, 2021 and 2020:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2021:			
Capitalized software costs	$ 1,770	$ (1,165)	$ 605
Trade names	102	—	102
Contracts	897	(128)	769
Other	102	(81)	21
Total	**$ 2,871**	**$ (1,374)**	**$ 1,497**
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**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2021 was as follows:

		Years Ending December 31,					
	Total	2022	2023	2024	2025	2026	Later Years
Amortization of intangible assets	$ 786	$ 147	$ 119	$ 108	$ 94	$ 73	$ 245

We recognized amortization expense of $188 million, $172 million and $188 million in the accompanying Consolidated Statements of Operations for the years ended December 31, 2021, 2020 and 2019, 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,	
	2021	2020
Marketable securities	$ 9	$ 3
Equity investments in unconsolidated healthcare entities	1,806	1,024
Total investments	1,815	1,027
Cash surrender value of life insurance policies	47	42
Long-term deposits	57	67
California provider fee program receivables	213	206
Operating lease assets	1,002	1,062
Land held for expansion, other long-term receivables and other assets	120	130
Investments and other assets	**$ 3,254**	**$ 2,534**

NOTE 14. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

	December 31,	
	2021	2020
Adjustments for defined benefit plans	$ (232)	$ (281)
Foreign currency translation adjustments and other	(1)	—
Accumulated other comprehensive loss	**$ (233)**	**$ (281)**

The income tax benefits (expense) allocated to the adjustments for our defined benefit plans was approximately $(14) million and $7 million for the years ended December 31, 2021 and 2020, 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 with Uninsured Patients* 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, individual hospitals and physician practices.

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

	Years Ended December 31,		
	2021	2020	2019
Hospital Operations:			
Net patient service revenues from hospitals and related outpatient facilities:			
Medicare	$ 2,615	$ 2,695	$ 2,888
Medicaid	1,254	1,081	1,193
Managed care	9,985	9,022	9,516
Uninsured	199	162	92
Indemnity and other	706	658	679
Total	14,759	13,618	14,368
Other revenues(1)	1,223	1,172	1,154
Hospital Operations total prior to inter-segment eliminations	**15,982**	**14,790**	**15,522**
Ambulatory Care	**2,718**	**2,072**	**2,158**
Conifer	**1,267**	**1,306**	**1,372**
Inter-segment eliminations	**(482)**	**(528)**	**(573)**
Net operating revenues	**$ 19,485**	**$ 17,640**	**$ 18,479**

(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, 2021, 2020 and 2019 by $26 million, $6 million and $27 million, respectively. Estimated cost report settlements and valuation allowances were 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,		
	2021	2020	2019
Net patient service revenues	$ 2,604	$ 1,960	$ 2,040
Management fees	86	86	95
Revenue from other sources	28	26	23
Net operating revenues	**$ 2,718**	**$ 2,072**	**$ 2,158**

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

	Years Ended December 31,		
	2021	2020	2019
Revenue cycle services – Tenet	$ 467	$ 514	$ 556
Revenue cycle services – other customers	705	700	713
Other services – Tenet	15	14	17
Other services – other customers	80	78	86
Net operating revenues	**$ 1,267**	**$ 1,306**	**$ 1,372**

Other services represented approximately 7% of Conifer's revenue for the year ended December 31, 2021 and included 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	2022	2023	2024	2025	2026	Later Years
Performance obligations	$ 6,181	$ 606	$ 606	$ 552	$ 552	$ 552	$ 3,313

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, 2021 through March 31, 2022, we have coverage totaling $850 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million for floods, $200 million for earthquakes and a per-occurrence sub-limit of $200 million for named windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and named windstorms, the total $850 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for California earthquakes, $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 we purchase insurance from third-parties to cover catastrophic claims. At December 31, 2021 and 2020, the aggregate current and long-term professional and general liability reserves in the accompanying Consolidated Balance Sheets were $1.045 billion and $978 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.

All commercial insurance we purchase is subject to per-claim and policy period aggregate limits. If the policy period aggregate limit of any of our 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.

Malpractice expense of $355 million, $320 million and $356 million was included in other operating expenses, net, in the accompanying Consolidated Statements of Operations for the years ended December 31, 2021, 2020 and 2019, respectively, of which $131 million, $120 million and $155 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.

Government Investigation of Detroit Medical Center

Detroit Medical Center ("DMC") is subject to an ongoing investigation commenced in October 2017 by the U.S. Attorney's Office for the Eastern District of Michigan and the Civil Division of the U.S. Department of Justice ("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. On September 28, 2021, the DOJ issued a civil investigative demand to DMC for documents and interrogatories. 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. In the three months ended December 31, 2021, we established a reserve of $23 million for certain obligations related to the sale of the hospitals and the subsequent bankruptcy proceedings of the buyers.

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, 2021, 2020 and 2019:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2021	$ 26	$ 116	$ (59)	$ (5)	$ 78
Year Ended December 31, 2020	$ 86	$ 44	$ (108)	$ 4	$ 26
Year Ended December 31, 2019	$ 8	$ 141	$ (55)	$ (8)	$ 86

During 2021, we also established estimated reserves of $39 million for various employment matters and made settlement payments of $11 million, which are included in the table above.

NOTE 18. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

We have a 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 Baylor holds in USPI. Each year starting in 2021, Baylor may put up to one-third of its total shares in USPI held as of April 1, 2017 (the "Baylor Shares") 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 it could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of Baylor's ownership interest by 2024. We have the ability to choose whether to settle the purchase price for the Baylor put/call, which is mutually agreed-upon fair market value, 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, 2021 and 2020.

Baylor did not deliver a put notice to us in January 2021 or January 2022. In February 2021, we notified Baylor of our intention to exercise our call option to purchase 33.3% of the Baylor Shares. We are continuing to negotiate the terms of that purchase. In addition, in February 2022, we notified Baylor of our intention to again exercise our call option to purchase an additional 33.3% of the Baylor Shares.

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries:

	December 31,	
	2021	2020
Balances at beginning of period	**$ 1,952**	**$ 1,506**
Net income	336	186
Distributions paid to noncontrolling interests	(217)	(135)
Accretion of redeemable noncontrolling interests	11	4
Purchases and sales of businesses and noncontrolling interests, net	121	391
Balances at end of period	**$ 2,203**	**$ 1,952**

The following tables show the composition by segment of our redeemable noncontrolling interests balances, as well as our net income available to redeemable noncontrolling interests:

	December 31,	
	2021	2020
Hospital Operations	$ 297	$ 267
Ambulatory Care	1,425	1,273
Conifer	481	412
Redeemable noncontrolling interests	**$ 2,203**	**$ 1,952**

	Years Ended December 31,		
	2021	2020	2019
Hospital Operations	$ 24	$ (33)	$ (37)
Ambulatory Care	243	153	159
Conifer	69	66	70
Net income available to redeemable noncontrolling interests	**$ 336**	**$ 186**	**$ 192**

NOTE 19. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2021, 2020 and 2019 consisted of the following:

	Years Ended December 31,		
	2021	2020	2019
Current tax expense (benefit):			
Federal	$ 50	$ —	$ (6)
State	111	30	26
	161	30	20
Deferred tax expense (benefit):			
Federal	267	(131)	140
State	(17)	4	—
	250	(127)	140
	$ 411	**$ (97)**	**$ 160**

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, 2021 includes $2 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 $2 million is included for the year ended December 31, 2021 to reflect the reduction in the valuation allowance. Foreign pre-tax loss was $5 million for the year ended December 31, 2021, $13 million for the year ended December 31, 2020, and $6 million for the year ended December 31, 2019.

	Years Ended December 31,		
	2021	2020	2019
Tax expense at statutory federal rate of 21%	$ 396	$ 141	$ 67
State income taxes, net of federal income tax benefit	77	33	21
Expired state net operating losses, net of federal income tax benefit	—	1	2
Tax benefit attributable to noncontrolling interests	(114)	(75)	(79)
Nondeductible goodwill	35	—	4
Nondeductible executive compensation	8	6	6
Nondeductible litigation costs	1	—	7
Expired charitable contribution carryforward	—	1	8
Stock-based compensation tax deficiencies (benefits)	(5)	(2)	4
Changes in valuation allowance	2	(226)	133
Change in tax contingency reserves, including interest	—	—	(14)
Prior-year provision to return adjustments and other changes in deferred taxes	8	14	(3)
Other items	3	10	4
Income tax expense (benefit)	**$ 411**	**$ (97)**	**$ 160**

The COVID Acts included a significant number of tax provisions applicable to individuals and businesses. For businesses, the COVID Acts made 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, 2021		December 31, 2020	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ —	$ 532	$ —	$ 621
Reserves related to discontinued operations and restructuring charges	2	—	8	—
Receivables (doubtful accounts and adjustments)	215	—	173	—
Medicare advance payments	209	—	—	—
Accruals for retained insurance risks	234	—	223	—
Intangible assets	—	396	—	385
Other long-term liabilities	23	—	55	—
Benefit plans	242	—	265	—
Other accrued liabilities	56	—	74	—
Investments and other assets	—	92	—	73
Interest expense limitation	10	—	8	—
Net operating loss carryforwards	99	—	566	—
Stock-based compensation	12	—	11	—
Right-of-use lease assets and obligations	208	208	224	224
Other items	48	44	86	39
	1,358	**1,272**	**1,693**	**1,342**
Valuation allowance	(57)	—	(55)	—
	$ 1,301	**$ 1,272**	**$ 1,638**	**$ 1,342**

Below is a reconciliation of the deferred tax assets and liabilities and the corresponding amounts reported in the accompanying Consolidated Balance Sheets.

	December 31,	
	2021	2020
Deferred income tax assets	$ 65	$ 325
Deferred tax liabilities	(36)	(29)
Net deferred tax asset	**$ 29**	**$ 296**

During the year ended December 31, 2021, the valuation allowance increased by $2 million, including an increase of $2 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 $2 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2021 was $57 million. 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 remaining balance in the valuation allowance at 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 as of 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 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, 2021, 2020 and 2019. 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, 2021, 2020 and 2019.

	Continuing Operations
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**
Increases due to tax positions taken in prior periods	3
Balance At December 31, 2021	**$ 34**

The total amount of unrecognized tax benefits as of December 31, 2021 was $34 million, of which $32 million, if recognized, would affect our effective tax rate and income tax benefit from continuing operations. Income tax expense in the year ended December 31, 2021 included expense of $3 million in continuing operations attributable to an increase 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, 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 included 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.

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, 2021.

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, 2017 remain subject to audit by the IRS.

As of December 31, 2021, 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, 2021, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $194 million pre-tax, $13 million of which expires in 2026 to 2036 and $181 million of which has no expiration date, (2) general business credit carryforwards of approximately $9 million expiring in 2034 through 2038, (3) charitable contribution carryforwards of approximately $90 million expiring in 2024 through 2025 and (4) state NOL carryforwards of approximately $3.333 billion expiring in 2022 through 2041 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $49 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, 2021, 2020 and 2019. 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, 2021			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 915	106,833	$ 8.56
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	1,738	(0.13)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 915**	**108,571**	**$ 8.43**
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)**

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the year ended December 31, 2019 because we did not report income from continuing operations available to common shareholders in that period. In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to common shareholders in the year ended December 31, 2019, the effect (in thousands) of employee stock options, RSUs 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

Fair Value Measurements

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. 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.

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. The following table presents this information about assets measured at fair value at December 31, 2020 and indicates the fair value hierarchy of the valuation techniques we utilized to determine such fair values:

	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	$ —

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 during the year ended December 31, 2020.

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, 2021 and 2020, the estimated fair value of our long-term debt was approximately 103.3% and 104.5%, respectively, of the carrying value of the debt.

NOTE 22. ACQUISITIONS

In December 2021, subsidiaries of USPI acquired ownership interests in 86 ambulatory surgery centers and related ambulatory support services (collectively, the "2021 SCD Centers") from Surgical Center Development #3, LLC and Surgical Center Development #4, LLC ("SCD"). Of these, we acquired controlling interests in 15 ambulatory surgery centers, noncontrolling interests in 57 centers and interests in 14 centers still in the development stage. The newly acquired facilities augmented our Ambulatory Care segment's existing musculoskeletal service line and expanded the number of markets it serves. We made a cash payment of $1.125 billion, net of cash acquired, to acquire these facilities. The 2021 SCD Centers are included in our Ambulatory Care segment.

In addition to the 2021 SCD Centers, we paid an aggregate purchase price of $74 million to acquire controlling interests in 11 outpatient businesses and various physician practices during the year ended December 31, 2021. During 2021, we also acquired a controlling interests in three surgical hospitals and two ambulatory surgery centers in which we previously owned a noncontrolling interest for $21 million. All of these facilities are included in our Ambulatory Care segment.

In December 2020, USPI acquired controlling interests in 45 ambulatory surgery centers (collectively, the "2020 SCD Centers") from SurgCenter Development and physician owners. The fair value of the consideration conveyed for the 2020 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 2020 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.

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 2021, including the 2021 SCD Centers, are 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, 2021, 2020 and 2019 are as follows:

	Years Ended December 31,		
	2021	2020	2019
Current assets	$ 59	$ 67	$ 16
Property and equipment	88	63	20
Other intangible assets	8	14	4
Goodwill	664	1,581	43
Other long-term assets, including previously held equity method investments	753	38	24
Current liabilities	(25)	(45)	(16)
Long-term liabilities	(70)	(43)	(35)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(139)	(478)	(18)
Noncontrolling interests	(95)	(20)	(7)
Cash paid, net of cash acquired	(1,220)	(1,177)	(25)
Gains on consolidations	**$ 23**	**$ —**	**$ 6**

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 $664 million from acquisitions completed during the year ended December 31, 2021 was recorded in our Ambulatory Care segment. Approximately $20 million, $14 million and $6 million in transaction costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2021, 2020 and 2019, 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, 2021 and 2019, we recognized gains totaling $23 million, and $6 million, respectively, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests. No such gains or losses were recognized in the year ended December 31, 2020.

Pro Forma Information - Unaudited

The following table provides certain pro forma information for Tenet as if the 2021 SCD Centers acquisition had occurred at the beginning of the year ended December 31, 2020:

	Year Ended December 31,	
	2021	2020
Net operating revenues	$ 19,627	$ 17,752
Equity in earnings of unconsolidated affiliates	$ 258	$ 192
Net income available to Tenet Healthcare Corporation common shareholders	$ 941	$ 416
Diluted earnings per share available to Tenet Healthcare Corporation common shareholders	$ 8.66	$ 3.92

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, imaging centers, ancillary outpatient facilities, micro-hospitals and physician practices. At December 31, 2021, our subsidiaries operated 60 hospitals serving primarily urban and suburban communities in nine states. On April 1, 2021, we transferred 24 imaging centers from our Ambulatory Care segment to our Hospital Operations segment. The total assets associated with the imaging centers transferred to our Hospital Operations segment constituted less than 1% of our consolidated total assets at March 31, 2021. In April 2021, we also completed the sale of the majority of the urgent care centers held by our Hospital Operations segment to an unaffiliated urgent care provider. In addition, we completed the sale of the Miami Hospitals in August 2021.

Our Ambulatory Care segment is comprised of the operations of USPI, in which we held an ownership interest of approximately 95% at December 31, 2021 and 2020. At December 31, 2021, USPI had interests in 399 ambulatory surgery centers (249 consolidated) and 24 surgical hospitals (eight consolidated) in 34 states. We completed the divestiture of 40 urgent care centers held by our Ambulatory Care segment on April 1, 2021.

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, 2021, Conifer provided services to approximately 650 Tenet and non-Tenet hospitals and other clients nationwide. In 2012, we entered into an agreement documenting the terms and conditions of various services Conifer provides to Tenet hospitals ("RCM Agreement"), as well as an agreement documenting certain administrative services our Hospital Operations segment provides to Conifer. In March 2021, we entered into a month-to-month agreement amending the RCM Agreement effective January 1, 2021 ("Amended RCM Agreement") to update certain terms and conditions related to the revenue cycle management services Conifer provides to Tenet hospitals. We believe the pricing terms for the services provided under the Amended RCM Agreement are commercially reasonable and consistent with estimated third-party terms. At December 31, 2021, we owned approximately 76% of Conifer Health Solutions, LLC, which is Conifer's principal subsidiary.

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,		
	2021	2020	2019
Assets:			
Hospital Operations	$ 17,173	$ 18,048	$ 16,196
Ambulatory Care	9,473	8,048	6,195
Conifer	933	1,010	974
Total	**$ 27,579**	**$ 27,106**	**$ 23,365**

	Years Ended December 31,		
	2021	2020	2019
Capital expenditures:			
Hospital Operations	$ 578	$ 467	$ 572
Ambulatory Care	66	51	75
Conifer	14	22	23
Total	**$ 658**	**$ 540**	**$ 670**
Net operating revenues:			
Hospital Operations total prior to inter-segment eliminations	$ 15,982	$ 14,790	$ 15,522
Ambulatory Care	2,718	2,072	2,158
Conifer			
Tenet	482	528	573
Other clients	785	778	799
Total Conifer revenues	1,267	1,306	1,372
Inter-segment eliminations	(482)	(528)	(573)
Total	**$ 19,485**	**$ 17,640**	**$ 18,479**
Equity in earnings of unconsolidated affiliates:			
Hospital Operations	$ 25	$ 6	$ 15
Ambulatory Care	193	163	160
Total	**$ 218**	**$ 169**	**$ 175**
Adjusted EBITDA:			
Hospital Operations	$ 1,931	$ 1,911	$ 1,449
Ambulatory Care	1,197	868	895
Conifer	355	367	386
Total	**$ 3,483**	**$ 3,146**	**$ 2,730**

	Years Ended December 31,		
	2021	2020	2019
Depreciation and amortization:			
Hospital Operations	$ 722	$ 739	$ 733
Ambulatory Care	95	81	72
Conifer	38	37	45
Total	**$ 855**	**$ 857**	**$ 850**
Adjusted EBITDA	**$ 3,483**	**$ 3,146**	**$ 2,730**
Income (loss) from divested and closed businesses	(1)	20	(2)
Depreciation and amortization	(855)	(857)	(850)
Impairment and restructuring charges, and acquisition-related costs	(85)	(290)	(185)
Litigation and investigation costs	(116)	(44)	(141)
Interest expense	(923)	(1,003)	(985)
Loss from early extinguishment of debt	(74)	(316)	(227)
Other non-operating income (expense), net	14	1	(5)
Net gains (losses) on sales, consolidation and deconsolidation of facilities	445	14	(15)
Income from continuing operations, before income taxes	**$ 1,888**	**$ 671**	**$ 320**

NOTE 24. RECENT ACCOUNTING STANDARDS

Recently Issued Accounting Standards

In October 2021, the FASB issued ASU 2021-08, "Business Combinations (Topic 805) – Accounting for Contract Assets and Contract Liabilities from Contracts with Customers" ("ASU 2021-08"). The standard addresses diversity in practice related to the recognition and measurement of contract assets and contract liabilities acquired in a business combination. The guidance requires an acquirer to recognize and measure contract assets and liabilities acquired in a business combination in accordance with Topic 606 – Revenue from Contracts with Customers as if the acquirer had originated the contracts, as opposed to at their fair value on the acquisition date. ASU 2021-08 is effective for us beginning in 2023, with early adoption permitted. We are currently evaluating the impact of this standard to our financial statements.

The FASB issued ASU 2021-10, "Government Assistance (Topic 832)" ("ASU 2021-10") in November 2021. The amendments in this update require additional disclosures regarding government grants and money contributions, including information on the nature of transactions and related accounting policies used to account for transactions, detail on the line items on the balance sheet and income statement affected by these transactions, and significant terms and conditions of the transactions. ASU 2021-10 is effective for us beginning in 2022, with early adoption permitted. The adoption of this guidance will not impact our financial position, results of operations or cash flows.

In August 2020, the FASB issued ASU 2020-06, "Accounting for Convertible Instruments and Contracts in an Entity's Own Equity" (ASU 2020-06"). Among other amendments, ASU 2020-06 changes the accounting for diluted earnings-per-share for convertible instruments and contracts that may be settled in cash or stock. Under current GAAP, entities can overcome the presumption of share settlement for convertible instruments and contracts that can be partially or fully settled in cash at the issuer's election. If successfully rebutted, entities can use the treasury stock method to determine the dilutive effect of these instruments and, under certain conditions, exclude them from diluted weighted average shares outstanding. ASU 2020-06 requires that the if-converted method, which is more dilutive than the treasury stock method, be used for all convertible instruments and eliminates an entity's ability to assume cash settlement for an instrument that may be share-settled. This standard is effective for the Company in the first quarter of fiscal 2022 and may be applied on a modified or fully retrospective basis. Although the adoption of this guidance will not impact our financial position or cash flows, it may result in an increase in the number of diluted weighted average shares outstanding utilized in our diluted earnings per share calculation.

Recently Adopted Accounting Standards

Effective January 1, 2021, we adopted 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 applied to all employers that sponsor defined benefit pension or other postretirement plans. The amendments in ASU 2018-14, removed, modified or added certain disclosure requirements as part of the FASB's disclosure framework project to improve the effectiveness of the notes to the financial statements. The adoption of this ASU did not impact our financial position, results of operations or cash flows.

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.

NOTE 25. SUBSEQUENT EVENT

On February 9, 2022, we called for the redemption of all $700 million aggregate principal amount outstanding of our 2025 Senior Secured First Lien Notes. We expect to redeem the notes on February 23, 2022 using cash on hand.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

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 84 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 85 herein.

There were no changes in our internal control over financial reporting during the quarter ended December 31, 2021 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

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 88 through 135.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 146).

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.

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) 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)

(i) 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)

(j) 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)

(k) 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)

(l) 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)

(m) 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)

(n) 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)

(o) Thirty-Seventh Supplemental Indenture dated as of June 2, 2021, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 4.250% Senior Secured First Lien Notes due 2029 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed June 2, 2021)

(p) Thirty-Eighth Supplemental Indenture dated as of December 1, 2021, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 4.375% Senior Secured First Lien Notes due 2030 (Incorporated by Reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed December 1, 2021)

(10) Material Contracts

(a) Amendment No. 6, dated as of April 19, 2021, 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, including as Exhibit A thereto a copy of the Amended and Restated Credit Agreement reflecting all amendments and restatements through April 19, 2021 (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed April 23, 2021)

(b) 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)

(c) 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)

(d) 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)

(e) 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)

(f) 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)

(g) 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)

(h) 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)

(i) 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)

(j) 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)

(k) 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)

(l) 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)

(m) 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)

(n) Sixth Amendment to Stock Pledge Agreement, dated as of July 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)

(o) 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)

(p) 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)

(q) Amended and Restated Employment Agreement between the Registrant and Saumya Sutaria, effective September 1, 2021 (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed September 3, 2021)*

(r) 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)*

(s) Amended and Restated Employment Agreement between the Registrant and Ronald A. Rittenmeyer, effective September 1, 2021 (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed September 3, 2021)*

(t) 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)*

(u) Retirement Agreement and General Release by and among the Registrant, Tenet Business Services Corporation and Audrey Andrews, dated December 30, 2021*

(v) 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)*

(w) Offer of Employment from the Registrant to Thomas W. Arnst, amended and restated as of February 2, 2022*

(x) Tenet Fifth Amended and Restated Executive Severance Plan, as amended and restated effective February 1, 2021 (Incorporated by reference to Exhibit 10(hh) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2020, filed February 19, 2021)*

(y) Form of Amendment to Executive Severance Plan Agreement*

(z) 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)*

(aa) 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)*

(bb) 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)*

(cc) 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)*

(dd) 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)*

(ee) 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)*

(ff) 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)*

(gg) 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)*

(hh) 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)*

(ii) 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)*

(jj) 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)*

(kk) Forms of Award used to evidence (i) grants of time-based restricted stock units to executives and (ii) grants of performance-based restricted stock units to executives, in each case after 2019 under the Tenet Healthcare 2019 Stock Incentive Plan*

(ll) Terms and Conditions of Restricted Stock Unit Awards and Terms and Conditions of Restricted Stock Unit Performance Awards, in each case granted to Saumya Sutaria, M.D. on September 1, 2021 under the Tenet Healthcare 2019 Stock Incentive Plan*

(mm) Form of Terms and Conditions of Restricted Stock Unit Awards granted to Ronald A. Rittenmeyer under the Tenet Healthcare 2019 Stock Incentive Plan*

(nn) Terms and Conditions of Restricted Stock Unit Awards granted to Audrey T. Andrews on February 24, 2021 under the Tenet Healthcare 2019 Stock Incentive Plan*

(oo) Terms and Conditions of Restricted Stock Unit Award and Terms and Conditions of Restricted Stock Unit Performance Award, in each case granted to Thomas W. Arnst on June 2, 2020 under the Tenet Healthcare 2019 Stock Incentive Plan*

(pp) 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)*

(qq) Sixth Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective November 3, 2021*

(rr) 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)*

(ss) 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) Consolidated Subsidiaries of the Registrant

(23) Consent of Deloitte & Touche LLP (PCAOB ID No. 34)

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Saumya Sutaria, M.D., Chief Executive Officer

(b) Certification of Daniel J. Cancelmi, Executive Vice President and Chief Financial Officer

(32) Section 1350 Certifications of Saumya Sutaria, M.D., 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 Registrant's Annual Report on Form 10-K for the year ended December 31, 2021 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 18, 2022 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 18, 2022	By:	/s/ SAUMYA SUTARIA Saumya Sutaria, M.D. Chief Executive Officer and Director *(Principal Executive Officer)*
Date: February 18, 2022	By:	/s/ DANIEL J. CANCELMI Daniel J. Cancelmi Executive Vice President and Chief Financial Officer *(Principal Financial Officer)*
Date: February 18, 2022	By:	/s/ R. SCOTT RAMSEY R. Scott Ramsey Senior Vice President, Controller *(Principal Accounting Officer)*
Date: February 18, 2022	By:	/s/ RONALD A. RITTENMEYER Ronald A. Rittenmeyer Executive Chairman and Director
Date: February 18, 2022	By:	/s/ JAMES L. BIERMAN James L. Bierman Director
Date: February 18, 2022	By:	/s/ RICHARD FISHER Richard Fisher Director
Date: February 18, 2022	By:	/s/ MEGHAN M. FITZGERALD Meghan M. FitzGerald, DrPH Director
Date: February 18, 2022	By:	/s/ CECIL D. HANEY Cecil D. Haney Director
Date: February 18, 2022	By:	/s/ J. ROBERT KERREY J. Robert Kerrey Director
Date: February 18, 2022	By:	/s/ CHRIS LYNCH Chris Lynch Director
Date: February 18, 2022	By:	/s/ RICHARD MARK Richard Mark Director
Date: February 18, 2022	By:	/s/ TAMMY ROMO Tammy Romo Director
Date: February 18, 2022	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)	Deductions	Other Items	Balance at End of Period
Valuation allowance for deferred tax assets:					
Year ended December 31, 2021	$ 55	$ 2	$ —	$ —	$ 57
Year ended December 31, 2020	$ 281	$ (226)	$ —	$ —	$ 55
Year ended December 31, 2019	$ 148	$ 133	$ —	$ —	$ 281

(1) Includes amounts recorded in discontinued operations.

DESCRIPTION OF SECURITIES REGISTERED PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

As of December 31, 2021, 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, 2021, $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(u)

RETIREMENT AGREEMENT AND GENERAL RELEASE

This Retirement Agreement and General Release (this "Agreement") is entered into by and among Tenet Healthcare Corporation ("Tenet"), Tenet Business Services Corporation (the "Company") and Audrey Andrews ("Executive") who agree as follows:

1. Executive's last day of employment with the Company will be April 15, 2022 ("Last Day Worked"). From January 1, 2022 through the Last Day Worked, Executive will serve as a non-executive senior advisor, providing transition services and support to Tenet and the Company at such times and places as are mutually agreed among the parties. Following December 31, 2021, Executive will not be authorized to bind or make any commitments on behalf of the Company and will no longer be an executive officer of Tenet. The Company will pay Executive all compensation due to her as of her Last Day Worked. Executive agrees that, except as expressly set forth herein, for all other purposes her employment will be formally terminated as of her Last Day Worked and the Company will have no further obligations to Executive.

2. The parties further agree to the following:

    a. Base Salary & Benefits: Executive shall receive a base salary of $750 per week from January 1, 2022 through the Last Day Worked, with such salary payments made in accordance with the standard payroll practices of the Company. Executive will also continue to be eligible for applicable medical, dental and prescription benefits through her Last Day Worked, but no other Company benefits after December 31, 2021.

    b. AIP Bonus: Executive will be eligible to receive a bonus payment for 2021 under the Fourth Amended Tenet Healthcare Corporation Annual Incentive Plan (as amended, the "AIP") as described in Section 11(c) of the AIP, which will be subject to achievement of applicable performance criteria and will be paid at the same time and pursuant to the same conditions applicable to active employees. Executive will not be eligible to receive a bonus payment for 2022 under the AIP.

    c. Long-term Incentives: Executive will continue to vest in her outstanding unvested awards in Restricted and Performance Stock, Performance Stock Options and Performance Cash through the Last Day Worked in accordance with the applicable vesting schedule for each grant. Executive will not be eligible to receive any additional Restricted or Performance Stock, Performance Stock Options, Performance Cash or other long-term incentive awards after December 31, 2021.

    d. SERP & ERA: Executive is a participant in the Tenet Healthcare Corporation Tenth Amended and Restated Supplemental Executive Retirement Plan (as amended, the "SERP") and the Eighth Amended and Restated Tenet Executive Retirement Account (as amended, the "ERA"). Executive will be entitled to payment of her vested SERP benefits in accordance with the terms and conditions of the SERP and the ERA. For the avoidance of doubt, the parties acknowledge and agree that Executive's services to the Company following December 31, 2021 are reasonably anticipated to permanently decrease to no more than 20 percent of the average level of bona fine services performed prior to such date and, therefore, that Executive shall have incurred a "separation from service" for purposes of the SERP and ERA on December 31, 2021. Executive agrees that nothing herein limits the enforceability of the Conditions Precedent under the SERP as set forth therein.

3. Executive agrees she will cooperate fully with Tenet, upon request, in relation to the defense, prosecution or other involvement in any continuing or future claims, lawsuits, charges, and internal or external investigations which arise out of events or business matters over which Executive had responsibility during her employment with the Company. Such continuing duty of cooperation shall include making herself available to the Company, upon reasonable notice, for depositions, interviews, and appearance as a witness, and furnishing information to Tenet and its legal counsel upon request. Tenet will reimburse actual documented reasonable out-of-pocket expenses necessarily incurred as a result of such cooperation, such as travel, lodging, and meals.

4. At all times following the date hereof, Executive will not directly or indirectly reveal, divulge or make known to any person or entity, or use for Executive's personal benefit, any information acquired during Executive's employment with Tenet and its subsidiaries with regard to the financial, business or other affairs of Tenet and its subsidiaries (including without limitation any list or record of persons or entities with which any member of Tenet and its subsidiaries has any dealings), other than:

   a. information already in the public domain, or

   b. information that Executive is required to disclose under the following circumstances:

      i. at the express direction of any authorized governmental entity;

      ii. pursuant to a subpoena or other court process;

      iii. as otherwise required by law or the rules, regulations, or orders of any applicable regulatory body; or

      iv. as otherwise necessary, in the opinion of counsel for Executive, to be disclosed by Executive in connection with any legal action or proceeding involving Executive and Tenet or the Company in her capacity as an employee, officer, director, or stockholder of Tenet or the Company.

   Executive will, at any time requested by the Company promptly deliver to the Company all memoranda, notes, reports, lists and other documents (and all copies thereof) relating to the business of which she may then possess or have under her control.

   The parties agree that no provision of this Agreement shall be construed or interpreted in any way to limit, restrict or preclude either party hereto from cooperating or communicating with any governmental agency in the performance of its investigatory or other lawful duties nor does the agreement limit the Executive's right to receive a statutory award for information provided to any governmental agency.

5. Executive covenants that she has no claim, grievance or complaint against Tenet currently pending before any state or federal court, agency, or tribunal; and hereby releases and discharges Tenet and all of its respective predecessors, successors, parents, subsidiaries, affiliated and/or related entities and its and their directors, officers, supervisors, executives, representatives and agents (hereinafter, "Tenet Releasees") from all statutory and common law claims that Executive has or may have against the Tenet Releasees arising prior to Executive's execution of this Agreement and/or arising out of or relating to her employment or separation therefrom (herein, "Released Claims"). The term "Released Claims" does not include any claim for vested benefits under the Tenet Healthcare Corporation 401(k) Retirement Savings Plan, the Tenet Employee Benefit Plan, the Deferred Compensation Plan, Tenet's Stock Incentive Plans, the SERP or the ERA. Without limitation, the Released Claims include claims arising under Title VII of the Civil Rights Act of 1964, as amended, the Americans with Disabilities Act, the Civil Rights Act of 1991, the Age Discrimination in Employment Act, the Employee Retirement Income Security Act, the Lilly Ledbetter Fair Pay Act, the Worker Adjustment and Retraining Notification Act, any analogous local or state laws or statutes in the state(s) in which Executive was last employed and any other claim based upon any act or omission of any of the Tenet Releasees occurring prior to Executive's execution of this Agreement. Executive further waives any right to any individual monetary or economic recovery or equitable relief against Tenet Releasees in any administrative proceeding or in any action, lawsuit, hearing or other proceeding instituted by any agency, person or entity, except to the extent such waiver is prohibited by law or expressly permitted herein.

6. This Agreement constitutes a voluntary waiver and release of Executive's rights and claims under the Age Discrimination in Employment Act and pursuant to the Older Workers Benefit Protection Act. Executive is hereby advised and is aware of her right to consult with legal counsel of her choice prior to signing this Agreement. Executive acknowledges that she has twenty-one (21) days during which to consider, sign and return this Agreement, but she may elect to return the executed agreement prior to the expiration of that time. Executive has the right to revoke this Agreement for a period of seven (7) days after her execution of the Agreement. This Agreement shall not become effective or enforceable until Executive executes this Agreement.

7. Section 1542 of the Civil Code of the State of California ("Section 1542") provides:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY.

Executive waives all rights under Section 1542 or any other law or statute of similar effect in any jurisdiction with respect to the Released Claims. Executive acknowledges that she understands the significance and specifically assumes the risk regarding the consequences of such release and such specific waiver of Section 1542 and analogous state or local law or statute. Executive acknowledges and agrees that this Agreement releases all Released Claims existing or arising prior to Executive's execution of this Agreement which Executive has or may have against the Tenet Releasees whether such claims are known or unknown and suspected or unsuspected by Executive and Executive forever waives all inquiries and investigations into any and all such claims.

8. Executive shall return to Tenet on Executive's Last Day Worked all property in her possession or control, including without limitation, equipment, telephones, credit cards, keys, pagers, tangible proprietary information, documents, computers and computer discs, files and data, which Executive prepared or obtained during the course of her employment with Tenet.

9. Executive and the Company hereby agree that any dispute, controversy or claim arising from Executive's relationship with Tenet or her separation therefrom, any dispute over the validity, enforcement, scope, breach or interpretation of this Agreement and any dispute regarding unreleased claims or future claims between the parties, including the arbitrability of any such dispute, which cannot be settled by mutual agreement, will be finally settled by binding arbitration in accordance with the applicable Employment Dispute Resolution Rules of the American Arbitration Association ("AAA"). The arbitrator shall have the authority to award any remedy that would have been available to Executive or the Company in court under applicable law and the decision of the arbitrator will be final, unappealable and binding. A judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The parties and the arbitrator will keep confidential, and will not disclose to any person, except the parties' advisors and legal representatives, or as may be required by law or to enforce in court an arbitrator's award, the existence of any controversy under this Section 9, the referral of any such controversy to arbitration or the status or resolution thereof. Notwithstanding the foregoing, this Section 9 shall not preclude or otherwise limit any member of Tenet from seeking injunctive relief in any court of competent jurisdiction. In the event that any court determines that this arbitration procedure is not binding, or otherwise allows any litigation regarding a dispute, claim, or controversy covered by this Agreement, the parties hereto hereby waive any and all right to a trial by jury in or with respect to such litigation.

10. Neither this Agreement nor anything contained herein shall be admissible in any proceeding as evidence of or an admission by any of the Tenet Releasees of any violation of any law or regulation or of any liability whatsoever to Executive. Notwithstanding the foregoing, this Agreement may be introduced into a proceeding solely for the purpose of enforcing this Agreement.

11. This Agreement contains the entire agreement and understanding between Tenet, the Company and Executive and supersedes all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning the subject matter hereof. This is an integrated document.

12. Should any provision, part or term of this Agreement be held to be invalid or unenforceable, the validity and enforceability of the remaining parts, terms and provisions shall not be affected thereby, and a suitable and equitable provision shall be substituted to carry out, so far as may be enforceable and valid, the intent and purpose of the invalid or unenforceable provision.

13. This Agreement shall be binding upon and shall inure to the benefit of Executive, Tenet, the Company and the Tenet Releasees and their respective heirs, administrators, successors and assigns.

14. This Agreement may be executed in counterparts, and each counterpart when executed shall have the efficacy of a signed original. Photographic copies of such signed counterparts may be used in lieu of the originals for any purpose.

15. This Agreement shall be construed and enforced in accordance with, and governed by, the laws of state of Texas.

16. Executive represents and affirms that she has carefully read and fully understands the provisions of this Agreement and that she is voluntarily entering into this Agreement.

DATED: December 30, 2021

/s/ Audrey Andrews
AUDREY ANDREWS

DATED: December 30, 2021

FOR TENET BUSINESS SERVICES CORPORATION

By /s/ Thomas Arnst

Its Chief Administrative Officer

DATED: December 30, 2021

FOR TENET HEALTHCARE CORPORATION

By /s/ Thomas Arnst

Its Chief Administrative Officer

Exhibit 10(w)

Offer of Employment
(Amended and Restated as of February 2, 2022)

We are excited to offer you the following position with Tenet Healthcare (Tenet or the Company):

- Position: Executive Vice President and Chief Administrative Officer at the Company headquarters located in Dallas, TX, where you will report to Saum Sutaria, M.D., Chief Executive Officer.

- Employment Entity: Tenet Employment, Inc.

- Start Date: March 10, 2021 (General Counsel as of April 19, 2021)

Compensation

- Base Salary: You will receive an annual base salary of $600,000, payable in accordance with the Company's standard payroll practices, currently bi-weekly, subject to applicable tax withholdings.

- Annual Incentive Plan (AIP): Your target cash bonus award will be 75% of your base salary. The AIP is performance-based cash compensation tied to the achievement of annual performance goals. The level of payout will depend on the realization of that year's goals in the Company's discretion. Awards are subject to modification, including for extraordinary events and/or failure to meet our quality, ethics or compliance guidelines. Participation in the AIP does not guarantee that an award will be made.

- Stock Incentive Plan (SIP) Award: You will be recommended for an annual award for the next planning cycle with an approximate grant date value of $1,500,000. Our awards are designed to align the incentives of our leadership team with the Company's long-term performance. Each year, the Company determines eligibility, award value and type of award (including whether in stock and/or cash or subject to performance conditions), with awards typically granted in February. Any award will be subject to the terms and conditions set forth in the applicable plan document and award agreement. Eligibility for the program does not guarantee an award will be made. Notwithstanding anything to the contrary, any awards prior to 2021 will continue to be treated upon a Qualifying Termination as set forth in your Conifer offer letter dated September 3, 2019, but any awards in or after 2021 will continue to vest as originally scheduled upon and after a Qualifying Termination that is outside of the Protection Period with respect to a Change of Control (such terms, as defined in the ESP).

Benefits

Your position is eligible for our comprehensive benefits package, including health and welfare benefits and the plans highlighted below. We will provide additional detail regarding all of our benefit plans during the Company's on-boarding process, including more information from our executive benefits team after your start date. All benefits are subject to the terms and conditions of the applicable plan documents, may be modified or terminated at any time, and may require special elections or the execution of additional agreements in order to participate.

- Retirement Plans: You will continue to be eligible to participate in the Company's 401(k) retirement savings plan which offers pretax, aftertax, and ROTH contribution and possible discretionary employer match opportunities. In addition, you will continue to be eligible for the Company's deferred compensation plan, which currently provides pre-tax deferral options with employer match opportunities.

- Executive Retirement Account (ERA): You will be eligible to receive an annual employer contribution equal to 20% of your base salary under the terms and conditions provided in the ERA. Employer contributions are made on July 1 each year.

- Executive Severance Plan (ESP): You will be eligible to participate in the Tenet ESP, which provides certain severance benefits in the event of a Qualifying Termination (as defined in the ESP). You will receive an ESP Agreement from our executive benefits team that requires your signature.

- Time Off: In addition to paid Company holidays, you are eligible for paid time off according to your tenure with the company.

Terms and Conditions of Employment

Confidentiality, Non-Compete, and Non-Solicitation Agreement: This offer is contingent upon your execution of the Agreement provided in Appendix A.

At-Will Employment; Cause: Your employment will be on an at-will basis, which means that either you or the Company may terminate the employment relationship, with or without notice and with or without cause, at any time. As used in this letter, the term "cause" shall include, but shall not be limited to, dishonesty, fraud, willful misconduct, breach of fiduciary duty, conflict of interest, commission of a felony, material failure or refusal to perform job duties in accordance with Company policies, a material violation of Company policy that causes harm to the Company or an affiliate, or other wrongful conduct of a similar nature and degree.

Compliance with Company Policies: You agree, as a condition to your employment, to abide by all Tenet Human Resources and other policies, procedures, rules and regulations currently in effect or that may be adopted from time to time, including the Tenet Standards of Conduct. To the extent that any such policies, rules or regulations, or any benefit plans in which you are a participant, conflict with the terms of this letter, the actual terms of those policies or plans shall control.

Conflict Resolution: This offer is contingent upon your execution of the Fair Treatment and Mutual Arbitration agreement provided in Appendix B, which includes final and binding arbitration as a resolution to any grievance that results from your employment or termination of employment with the Company.

Acknowledged and Accepted

/s/ Thomas W. Arnst Date: 2/14/2022
Thomas W. Arnst (*Signature*)

Tenet Employment, Inc.

/s/ Kelly L. Pool Date: 2/14/2022
Kelly Pool
Vice President, Human Resources

TENET HEALTHCARE CORPORATION

[Date]

[Covered Executive]
By Email

Re: Amendment to Executive Severance Plan Agreement

Dear [Covered Executive],

This letter is intended to confirm our mutual understanding with respect to an amendment to the Tenet Executive Severance Plan Agreement (the "***Agreement***") by and between you and Tenet Healthcare Corporation ("***Tenet***") regarding your participation in the Tenet Executive Severance Plan (the "***ESP***"). Capitalized terms used but not otherwise defined herein shall have the meanings ascribed to such terms in the ESP.

In order to induce you to continue your employment with Tenet and its affiliates, effective immediately upon execution of this letter, the Agreement is hereby amended as follows:

(1) Notwithstanding the provisions of Article VI of the ESP and irrespective of any advance notice, the ESP will not be amended, terminated or suspended in any way that materially reduces the rights or benefits of the Covered Executive without the Covered Executive's written consent, which may be provided in the sole discretion of the Covered Executive.

(2) Notwithstanding anything to the contrary, any unvested stock incentive plan award(s) to Covered Executive will continue to vest as originally scheduled upon and after a Qualifying Termination that is outside of the Protection Period with respect to a Change of Control.

Except as explicitly amended by this letter, the ESP and the Agreement shall remain in full force and effect in accordance with its term.

Please execute a copy of this letter and return it to me to acknowledge that you are in agreement with the amendment to the Agreement described above.

Sincerely,

TENET HEALTHCARE CORPORATION

By: _____
Name:
Title:

Acknowledged and agreed to by:

[Covered Executive]_____

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT AWARDS

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan, as such may be amended from time to time (the "**Plan**"), to make awards of restricted stock units and to determine the terms of such restricted stock units.

On **[Grant Date]** (the "**Grant Date**"), the Committee granted you, **[Participant Name]** ("**You**"), an award of restricted stock units (the "**RSUs**"). The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing the right to receive **[Shares Granted]** Shares in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Vesting. Subject to Sections 3 and 4 below, the RSUs will vest as follows: (a) one-third will vest on the first anniversary of the Grant Date, (b) one-third will vest on the second anniversary of the Grant Date, and (c) one-third will vest on the third anniversary of the Grant Date (each one-year period, a "**Vesting Period**").

   If Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason other than as set forth in Sections 3 or 4 below, Your unvested RSUs will automatically be cancelled upon such termination of employment or services in exchange for no consideration.

3. Certain Termination Events.

   a. *Death or Disability.* All unvested RSUs will fully vest on the date of Your termination of employment in the event Your employment is terminated for any of the following reasons:

      i. Death, or

      ii. Disability (as defined under section 409A(a)(2)(C)(ii) of the Code).

   b. *Retirement on or after age 62 or Qualifying Termination*. On the date of Your termination of employment as a result of Your retirement on or after reaching age 62 or a Qualifying Termination, a pro-rated portion (based on the number of months You are actually employed during the applicable Vesting Period) of Your RSUs will vest and settle.

4. Change in Control. In the event of a Change in Control, the following provisions will apply:

   a. If the successor company assumes the RSUs or substitutes other restricted stock units for such RSUs (or agrees to assume or substitute such awards) and You incur a Qualifying Termination within the Protection Period, unvested RSUs (or substitute restricted stock units) will fully vest on the later of (i) the date of Your Qualifying Termination or (ii) immediately prior to the occurrence of the Change in Control.

   b. If the successor company does not assume the RSUs, or substitute other restricted stock units for the RSUs, unvested RSUs will fully vest immediately prior to the occurrence of the Change in Control.

In the event You incur a Qualifying Termination not within the Protection Period, the provisions of Section 3 will apply.

5. Settlement; Tax Withholding. Upon the vesting of Your RSUs, Your RSUs will be settled in Shares within 60 days and You will recognize ordinary income. Notwithstanding the foregoing, to the extent required to comply with Section 409A of the Code, if You are a "specified employee" within the meaning of Section 409A of the Code, and the vesting of Your RSUs is triggered as a result of Your termination of employment, the delivery of Shares shall be delayed until (a) the six-month anniversary of Your separation from service (within the meaning of Section 409A) or, (b) if earlier, as soon as practicable following Your death. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (i) have the Company withhold Shares having a Fair Market Value equal to the amount of the tax withholding or (ii) require You to pay to the Company the amount of the tax withholding.

6. Rights as Shareholder. You will not have any rights of a shareholder prior to the receipt of Your Shares, and will obtain such rights only upon Your receipt of the Shares, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares or cash distributed as dividends with respect to the Shares underlying the RSUs will be subject to the same vesting schedule as the underlying RSUs and shall be settled as provided in Section 5.

7. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

8. Clawback. Any RSUs You are granted hereunder and/or Shares you receive in settlement of such RSUs shall be subject to recovery by the Company in the circumstances and manner provided in any Incentive Compensation Clawback Policy that may be adopted or implemented by the Company and in effect from time to time on or after the date hereof, and You shall effectuate any such recovery at such time and in such manner as the Company may specify. For purposes of this Certificate, the term "**Incentive Compensation Clawback Policy**" means and includes any policy of the type contemplated by Section 10D of the Securities Exchange Act, any rules or regulations of the Securities and Exchange Commission adopted pursuant thereto, or any related rules or listing standards of any national securities exchange or national securities association applicable to the Company.

9. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

10. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

11. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Code.

12. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

13. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

14. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

15. Entire Understanding. This Certificate and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

16. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada, without reference to principles of conflict of laws.

Electronic Signature: **[Electronic Signature]**

Acceptance Date: **[Acceptance Date]**

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT PERFORMANCE AWARDS

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan, as such may be amended from time to time (the "**Plan**"), to make awards of restricted stock units ("**RSUs**") and to determine the terms of such RSUs.

On **[Grant Date]** (the "**Grant Date**"), the Committee granted you, **[Participant Name]** ("**You**"), an award of RSUs. The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing the right to earn **[Shares Granted]** Shares based upon target achievement of applicable performance goals (the "**Target RSUs**") and up to a maximum of 200% of the Target RSUs in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Performance Criteria.

   a. *Performance Period.* Your RSUs are subject to a three-year performance period that begins on _____ __, 20__ and ends on _____ __, 20__ (the "**Performance Period**").

   b. *Performance Measures.* Your RSUs will provisionally vest based on the Company's achievement of the performance goals as follows:

      i. Between 0% and 200% of one-third of the Target RSUs will vest based on achievement of the 20__ performance goals set forth in Appendix A for fiscal year 20__;

      ii. Between 0% and 200% of one-third of the Target RSUs will vest based on achievement of the 20__ performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 20__; and

      iii. Between 0% and 200% of one-third of the Target RSUs will vest based on achievement of the 20__ performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 20__.

   Following completion of the Performance Period, the provisionally vested RSUs will be subject to adjustment based on the Company's Relative TSR (as defined in Appendix A) for the Performance Period as set forth in Appendix A. The performance goals set forth in Appendix A for fiscal year 20__ and each of the performance goals established by the Committee for fiscal years 20__ and 20__ shall be collectively referred to herein as the "**Performance Criteria**".

3. Vesting. The RSUs that have provisionally vested under Section 2 above will vest on the third anniversary of the Grant Date (the "**Vesting Date**"). If Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason prior to the Vesting Date, other than as set forth in Section 4 or 5 below, Your unvested RSUs (even if provisionally vested) will be automatically cancelled.

4. Certain Termination Events. Your unvested RSUs will vest as follows in the event any of the following events (each, a "**Termination Event**") occurs prior to the Vesting Date:

   a. Death or Disability (as defined under section 409A(a)(2)(C)(ii) of the Internal Revenue Code): A pro-rated portion (based on the number of months You are actually employed during the Performance Period) of Your RSUs will vest on the date of such a Termination Event based on (i) the Company's actual performance with respect to the applicable Performance Criteria during such completed portion of the Performance Period that has provisionally vested on or prior to such a Termination Event and (ii) assuming target achievement of the applicable Performance Criteria for such incomplete portion of the Performance Period that has not provisionally vested on or prior to such a Termination Event.

   b. Qualifying Termination or Retirement (retirement on or after age 62): A pro-rated portion (based on the number of months You are actually employed during the Performance Period) of Your RSUs will vest on the Vesting Date, taking into account the Company's actual performance with respect to the applicable Performance Criteria.

5. Change in Control. In the event of a Change in Control, the following provisions will apply:

   a. If the successor company assumes the RSUs or substitutes other restricted stock units for such RSUs (or agrees to assume or substitute such awards) and you incur a Termination Event within the Protection Period, the unvested RSUs (or substitute restricted stock units) will vest as provided in Section 4 above.

   b. If the successor company does not assume the RSUs, or substitute other restricted stock units for the RSUs, and if either (i) the Change in Control occurs within the Performance Period, then each of the Performance Criteria will be deemed to have been met at the target level and unvested RSUs representing the Target RSUs will fully vest immediately prior to the occurrence of the Change in Control or (ii) the Change in Control occurs after the end of the Performance Period, but prior to the Vesting Date, then Your provisionally vested RSUs will fully vest immediately prior to the occurrence of the Change in Control.

   c. In lieu of (a) or (b), the Committee may declare the level at which the Performance Criteria are deemed to be met and the unvested RSUs will vest to that extent immediately prior to the occurrence of the Change in Control.

6. Settlement; Tax Withholding. Upon the vesting of Your RSUs, Your RSUs will be settled in Shares within sixty (60) days and You will recognize ordinary income. Notwithstanding the foregoing, to the extent required to comply with Section 409A of the Code, if You are a "specified employee" within the meaning of Section 409A of the Code, and the vesting of Your RSUs is triggered as a result of Your termination of employment, the delivery of Shares shall be delayed until (a) the six-month anniversary of Your separation from service (within the meaning of Section 409A), or (b) if earlier, as soon as practicable following Your death. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (i) have the Company withhold Shares having a Fair Market Value equal to the amount of the tax withholding or (ii) require You to pay to the Company the amount of the tax withholding.

7. Rights as Shareholder. You will not have any rights of a shareholder prior to the receipt of Your Shares, and will obtain such rights only upon Your receipt of the Shares, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares or cash distributed as dividends with respect to the Shares subject to the RSUs will be subject to the same vesting schedule and performance conditions as the underlying RSUs and shall be settled as provided in Section 6.

8. Clawback. Any RSUs You are granted hereunder and/or Shares you receive in settlement of such RSUs shall be subject to recovery by the Company in the circumstances and manner provided in any Incentive Compensation Clawback Policy that may be adopted or implemented by the Company and in effect from time to time on or after the date hereof, and You shall effectuate any such recovery at such time and in such manner as the Company may specify. For purposes of this Certificate, the term "**Incentive Compensation Clawback Policy**" means and includes any policy of the type contemplated by Section 10D of the Securities Exchange Act, any rules or regulations of the Securities and Exchange Commission adopted pursuant thereto, or any related rules or listing standards of any national securities exchange or national securities association applicable to the Company. Until the Company adopts such an Incentive Compensation Clawback Policy, the following clawback provision shall apply to the RSUs:

   In the event that, within three years of the end of the Performance Period, the Company restates its financial results with respect to the Company's performance during the Performance Period due to material non-compliance with any financial reporting requirement under the securities laws as generally applied and the Board of Directors determines Your fraud or misconduct caused or partially caused the need for the restatement, then the Board of Directors shall require You to immediately return to the Company the RSUs or any Shares you receive in settlement of the RSUs or the pre-tax income derived from any disposition of the Shares previously received in settlement of the RSUs (plus a reasonable rate of interest if deemed appropriate by the Board of Directors) that would not have been granted and/or vested, as determined in the sole discretion of the Board, based upon the restated financial results.

9. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

10. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

11. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

12. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Code.

13. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

14. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

15. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

16. Entire Understanding. This Certificate and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

17. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada, without reference to principles of conflict of laws.

Electronic Signature: **[Electronic Signature]**

Acceptance Date: **[Acceptance Date]**

Exhibit 10(ll)

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT AWARDS

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan, as amended (the "**Plan**"), to make awards of restricted stock units ("**RSUs**") and to determine the terms of such RSUs.

On 09/01/2021 (the "**Grant Date**"), the Committee granted SAUMYA SUTARIA ("**You**") RSUs. The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing 53,341 Shares in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Vesting. The RSUs will vest in full on August 31, 2025 (the "**Vesting Date**"); provided You remain an employee of the Company on such date. If Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason prior to the Vesting Date, other than as set forth in Section 3 below, Your unvested RSUs will be automatically cancelled.

3. Certain Termination Events. Your unvested RSUs will vest in accordance with Section 4 of the or the Amended and Restated Employment Agreement by and between You and the Company, effective as of September 1st, 2021 (the "**Employment Agreement**") following a termination of Your employment. Any unvested RSUs that do not vest and are not eligible to vest in the future in accordance with Section 4 of the Employment Agreement upon Your termination of employment will be automatically cancelled as of the date of such terminated or such later date as such RSUs are no longer eligible to vest.

4. Tax Withholding. Except as otherwise provided in the Employment Agreement, upon the vesting of Your RSUs, Your RSUs will be settled in Shares within 30 days and You will recognize ordinary income. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (a) have the Company withhold Shares having a Fair Market Value equal to the amount of the minimum tax withholding or (b) require You to pay to the Company the amount of the tax withholding.

5. Rights as Shareholder. You will not have any rights of a shareholder prior to the vesting of the RSUs, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares distributed as dividends with respect to the Shares subject to the RSUs will be subject to the same vesting schedule as the underlying RSUs.

6. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

7. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

8. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

9. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Internal Revenue Code.

10. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

11. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

12. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

13. Entire Understanding. This Certificate embodies the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

14. Governing Law. This Grant shall be governed by, and construed in accordance with, the laws of the State of Nevada.

Electronic Signature: **Signed Electronically**

Acceptance Date: **09/25/2021**

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT PERFORMANCE AWARDS

The Human Resources Committee (the "Committee") of the Board of Directors of Tenet Healthcare Corporation (the "Company") is authorized under the Company's 2019 Stock Incentive Plan, as such may be amended from time to time (the "Plan"), to make awards of restricted stock units ("RSUs") and to determine the terms of such RSUs.

On 09/01/2021 (the "Grant Date"), the Committee granted you, SAUMYA SUTARIA ("You"), an award of RSUs. The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "Certificate"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing the right to earn 53,341 Shares based upon target achievement of applicable performance goals (the "Target RSUs") and up to a maximum of 200% of the Target RSUs in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Performance Criteria.

   a. *Performance Period.* Your RSUs are subject to a performance period that begins on January 1, 2021 and ends on June 30, 2025 (the "Performance Period").

   b. *Performance Measures.* Your RSUs will provisionally vest based on the Company's achievement of the performance goals as follows:

      i. Between 0% and 200% of one-eighth of the Target RSUs will vest based on achievement of the calendar 2021 performance goals set forth in Appendix A;

      ii. Between 0% and 200% of one-quarter of the Target RSUs will vest based on achievement of the calendar 2022 performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 2022;

      iii. Between 0% and 200% of one-quarter of the Target RSUs will vest based on achievement of the calendar 2023 performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 2023;

      iv. Between 0% and 200% of one-quarter of the Target RSUs will vest based on achievement of the calendar 2024 performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 2024; and

      v. Between 0% and 200% of one-eighth of the Target RSUs will vest based on achievement of the first and second quarter 2025 performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 2025.

   Following completion of the Performance Period, the provisionally vested RSUs will be subject to adjustment based on the Company's Relative TSR (as defined in Appendix A) for the Performance Period as set forth in Appendix A. The performance goals established by the Committee shall be collectively referred to herein as the "Performance Criteria".

3. Vesting. The RSUs that have provisionally vested under Section 2 above will vest on August 31, 2025 (the "Vesting Date"). If Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason prior to the Vesting Date, other than as set forth in Section 4 or 5 below, Your unvested RSUs (even if provisionally vested) will be automatically cancelled.

4. Certain Termination Events. Your unvested RSUs will vest in accordance with Section 4 of the Amended and Restated Employment Agreement by and between You and the Company, effective as of September 1st, 2021 (the "Employment Agreement") following a termination of Your employment. Any unvested RSUs that do not vest and are not eligible to vest in the future in accordance with Section 4 of the Amended and Restated Employment Agreement upon Your termination of employment will be automatically cancelled as of the date of such termination or such later date as such RSUs are no longer eligible to vest.

5. Change in Control. In the event of a Change in Control, the following provisions will apply:

   a. If the successor company assumes the RSUs or substitutes other restricted stock units for such RSUs (or agrees to assume or substitute such awards) and you incur a Termination Event within the Protection Period, the unvested RSUs (or substitute restricted stock units) will vest as provided in Section 4 above.

   b. If the successor company does not assume the RSUs, or substitute other restricted stock units for the RSUs, and if either (i) the Change in Control occurs within the Performance Period, then each of the Performance Criteria will be deemed to have been met at the target level and unvested RSUs representing the Target RSUs will fully vest immediately prior to the occurrence of the Change in Control or (ii) the Change in Control occurs after the end of the Performance Period, but prior to the Vesting Date, then Your provisionally vested RSUs will fully vest immediately prior to the occurrence of the Change in Control.

   c. In lieu of (a) or (b), the Committee may declare the level at which the Performance Criteria are deemed to be met and the unvested RSUs will vest to that extent immediately prior to the occurrence of the Change in Control.

6. Settlement; Tax Withholding. Upon the vesting of Your RSUs, Your RSUs will be settled in Shares within sixty (60) days and You will recognize ordinary income. Notwithstanding the foregoing, to the extent required to comply with Section 409A of the Code, if You are a "specified employee" within the meaning of Section 409A of the Code, and the vesting of Your RSUs is triggered as a result of Your termination of employment, the delivery of Shares shall be delayed until (a) the six-month anniversary of Your separation from service (within the meaning of Section 409A), or (b) if earlier, as soon as practicable following Your death. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (i) have the Company withhold Shares having a Fair Market Value equal to the amount of the tax withholding or (ii) require You to pay to the Company the amount of the tax withholding.

7. Rights as Shareholder. You will not have any rights of a shareholder prior to the receipt of Your Shares, and will obtain such rights only upon Your receipt of the Shares, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares or cash distributed as dividends with respect to the Shares subject to the RSUs will be subject to the same vesting schedule and performance conditions as the underlying RSUs and shall be settled as provided in Section 6.

8. Clawback. Any RSUs You are granted hereunder and/or Shares you receive in settlement of such RSUs shall be subject to recovery by the Company in the circumstances and manner provided in any Incentive Compensation Clawback Policy that may be adopted or implemented by the Company and in effect from time to time on or after the date hereof, and You shall effectuate any such recovery at such time and in such manner as the Company may specify. For purposes of this Certificate, the term "**Incentive Compensation Clawback Policy**" means and includes any policy of the type contemplated by Section 10D of the Securities Exchange Act, any rules or regulations of the Securities and Exchange Commission adopted pursuant thereto, or any related rules or listing standards of any national securities exchange or national securities association applicable to the Company. Until the Company adopts such an Incentive Compensation Clawback Policy, the following clawback provision shall apply to the RSUs:

   In the event that, within three years of the end of the Performance Period, the Company restates its financial results with respect to the Company's performance during the Performance Period due to material non-compliance with any financial reporting requirement under the securities laws as generally applied and the Board of Directors determines Your fraud or misconduct caused or partially caused the need for the restatement, then the Board of Directors shall require You to immediately return to the Company the RSUs or any Shares you receive in settlement of the RSUs or the pre-tax income derived from any disposition of the Shares previously received in settlement of the RSUs (plus a reasonable rate of interest if deemed appropriate by the Board of Directors) that would not have been granted and/or vested, as determined in the sole discretion of the Board, based upon the restated financial results.

9. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

10. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

11. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

12. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Code.

13. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

14. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

15. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

16. Entire Understanding. This Certificate and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

17. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada, without reference to principles of conflict of laws.

Electronic Signature: **Signed Electronically**

Acceptance Date: 09/25/2021

Exhibit 10(mm)

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT AWARD

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan (the "**Plan**") to make awards of restricted stock units ("**RSUs**") and to determine the terms of such RSUs.

On **[Grant Date]** (the "**Grant Date**"), the Committee granted Ronald A. Rittenmeyer ("**You**") RSUs. The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing **[Shares Granted]** Shares in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Vesting. Except as otherwise provided in Section 3 below, the RSUs will vest in equal quarterly installments according to the following schedule; provided You remain an employee of the Company on each applicable vesting date:

[Schedule of Quarterly Installment Dates]

3. Termination of Employment. All unvested RSUs will vest in the event Your employment is terminated for any of the following reasons:

   - Death;
   - Disability (as defined in the Employment Agreement by and between You and the Company, as amended (the "**Employment Agreement**")); and
   - A termination of Your employment by the Company other than for Cause or by You for Good Reason (as such terms are defined in the Employment Agreement).

4. Tax Withholding. Except as otherwise provided in the Employment Agreement, upon the vesting of Your RSUs, Your RSUs will be settled in Shares within 30 days and You will recognize ordinary income. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (a) have the Company withhold Shares having a Fair Market Value equal to the amount of the minimum tax withholding or (b) require You to pay to the Company the amount of the tax withholding.

5. Rights as Shareholder. You will not have any rights of a shareholder prior to the vesting of the RSUs, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares distributed as dividends with respect to the Shares subject to the RSUs will be subject to the same vesting schedule as the underlying RSUs.

6. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

7. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

8. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

9. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Internal Revenue Code.

10. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

11. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

12. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

13. Entire Understanding. This Certificate, the Employment Agreement and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

14. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada.

Electronic Signature: **[Electronic Signature]**

Acceptance Date: **[Acceptance Date]**

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT AWARDS

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan, as such may be amended from time to time (the "**Plan**"), to make awards of restricted stock units and to determine the terms of such restricted stock units.

On 02/24/2021 (the "**Grant Date**"), the Committee granted you, AUDREY TEAGARDEN ANDREWS **("You**"), an award of restricted stock units (the "**RSUs**"). The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing the right to receive 14,192 Shares in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Vesting. Subject to Sections 3 and 4 below, the RSUs will vest in full on 12/31/2021 (the period from the Grant Date through such vesting date, the "**Vesting Period**").

   If Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason other than as set forth in Sections 3 or 4 below, Your unvested RSUs will automatically be cancelled upon such termination of employment or services in exchange for no consideration.

3. Certain Termination Events.

   a. *Death or Disability.* All unvested RSUs will fully vest on the date of Your termination of employment in the event Your employment is terminated for any of the following reasons:

      i. Death, or

      ii. Disability (as defined under section 409A(a)(2)(C)(ii) of the Code).

   b. *Qualifying Termination*. On the date of Your termination of employment as a result of a Qualifying Termination, a pro-rated portion (based on the number of months You are actually employed during the applicable Vesting Period) of Your RSUs will vest and settle.

4. Change in Control. In the event of a Change in Control, the following provisions will apply:

   a. If the successor company assumes the RSUs or substitutes other restricted stock units for such RSUs (or agrees to assume or substitute such awards) and You incur a Qualifying Termination within the Protection Period, unvested RSUs (or substitute restricted stock units) will fully vest on the later of (i) the date of Your Qualifying Termination or (ii) immediately prior to the occurrence of the Change in Control.

   b. If the successor company does not assume the RSUs, or substitute other restricted stock units for the RSUs, unvested RSUs will fully vest immediately prior to the occurrence of the Change in Control.

   In the event You incur a Qualifying Termination not within the Protection Period, the provisions of Section 3 will apply.

5. Settlement; Tax Withholding. Upon the vesting of Your RSUs, Your RSUs will be settled in Shares within sixty (60) days and You will recognize ordinary income. Notwithstanding the foregoing, to the extent required to comply with Section 409A of the Code, if You are a "specified employee" within the meaning of Section 409A of the Code, and the vesting of Your RSUs is triggered as a result of Your termination of employment, the delivery of Shares shall be delayed until (a) the six-month anniversary of Your separation from service (within the meaning of Section 409A) or, (b) if earlier, as soon as practicable following Your death. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (i) have the Company withhold Shares having a Fair Market Value equal to the amount of the tax withholding or (ii) require You to pay to the Company the amount of the tax withholding.

6. Rights as Shareholder. You will not have any rights of a shareholder prior to the receipt of Your Shares, and will obtain such rights only upon Your receipt of the Shares, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares or cash distributed as dividends with respect to the Shares underlying the RSUs will be subject to the same vesting schedule as the underlying RSUs and shall be settled as provided in Section 5.

7. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

8. Clawback. Any RSUs You are granted hereunder and/or Shares you receive in settlement of such RSUs shall be subject to recovery by the Company in the circumstances and manner provided in any Incentive Compensation Clawback Policy that may be adopted or implemented by the Company and in effect from time to time on or after the date hereof, and You shall effectuate any such recovery at such time and in such manner as the Company may specify. For purposes of this Certificate, the term "Incentive Compensation Clawback Policy" means and includes any policy of the type contemplated by Section 10D of the Securities Exchange Act, any rules or regulations of the Securities and Exchange Commission adopted pursuant thereto, or any related rules or listing standards of any national securities exchange or national securities association applicable to the Company.

9. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

10. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

11. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Code.

12. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

13. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

14. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

15. Entire Understanding. This Certificate and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

16. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada, without reference to principles of conflict of laws.

Electronic Signature: **Signed Electronically**

Acceptance Date: **04/27/2021**

Exhibit 10(oo)

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT AWARD

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan, as such may be amended from time to time (the "**Plan**"), to make awards of restricted stock units ("**RSUs**") and to determine the terms of such RSUs.

On **06/02/2020** (the "**Grant Date**"), the Committee granted you, **THOMAS W ARNST** ("**You**"), an award of RSUs. The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing the right to receive 22,615 Shares in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Vesting. Subject to Sections 3 and 4 below, the RSUs will vest as follows: (a) one-third will vest 2/28/2021, (b) one-third will vest on 2/28/2022, and (c) one-third will vest on 2/28/2023 (each one-year period, a "**Vesting Period**").

   Except as otherwise expressly set forth in any written agreement with You or severance plan applicable to You, if Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason other than as set forth in Sections 3 or 4 below, Your unvested RSUs will automatically be cancelled in exchange for no consideration.

3. Certain Terminations.

   a. Notwithstanding anything to the contrary, all unvested RSUs will fully vest on the date of Your termination of employment in the event Your employment is terminated for any of the following reasons:

      i. Death, or

      ii. Disability (as defined under section 409A(a)(2)(C)(ii) of the Code), or

      iii. Qualifying Termination.

   b. Retirement on or after age 62. Except as otherwise set forth in any written agreement with You or severance plan applicable to You, on the date of Your termination of employment as a result of Your retirement on or after reaching age 62 , a pro-rated portion (based on the number of months You are actually employed during the applicable Vesting Period) of Your RSUs will vest and settle.

      For purposes hereof, and for the avoidance of doubt, employment by any Tenet Healthcare Corporation consolidated subsidiary or affiliate (collectively, "Tenet") will be treated as a continuation of Your employment for all purposes, and You will not be deemed to have experienced a termination of employment as long as You remain continuously employed by any such employer. Furthermore, in no event will a Qualifying Termination occur as the result of any voluntary resignation (without Good Reason) or solely by reason of a spin-off of Conifer Health Solutions, LLC ("Conifer"), any successor to Conifer, or the assets of Conifer.

4. Change in Control. Except as otherwise set forth in any written agreement with You or severance plan applicable to You, in the event of a Change in Control, the following provisions will apply:

   a. If the successor company assumes the RSUs or substitutes other restricted stock units for such RSUs (or agrees to assume or substitute such awards) and You incur a Qualifying Termination within the period beginning on the date that is six (6) months before the occurrence of a Change in Control and ending twenty-four (24) months after the occurrence of a Change in Control, unvested RSUs (or substitute restricted stock units) will fully vest on the later of (i) the date of Your Qualifying Termination or (ii) immediately prior to the occurrence of the Change in Control.

   b. If the successor company does not assume the RSUs, or substitute other restricted stock units for the RSUs, unvested RSUs will fully vest immediately prior to the occurrence of the Change in Control.

   In the event You incur a Qualifying Termination not within the period beginning on the date that is six (6) months before the occurrence of a Change in Control and ending twenty-four (24) months after the occurrence of a Change in Control, the provisions of Section 3 will apply.

   For purposes of this Section 4, any reference to the "Company" in the definition of "Change in Control" shall be deemed to refer to the "Company or Conifer Health Solutions, LLC" and references to the Board shall be deemed to refer to the Board of Directors of the Company or the Board of Managers of Conifer. Notwithstanding the foregoing, a spin-off of Conifer, any successor to Conifer, or the assets of Conifer shall not give rise to a "Change in Control."

5. Settlement; Tax Withholding. Upon the vesting of Your RSUs, Your RSUs will be settled in Shares within 60 days and You will recognize ordinary income. Notwithstanding the foregoing, to the extent required to comply with Section 409A of the Code, if You are a "specified employee" within the meaning of Section 409A of the Code, and the vesting of Your RSUs is triggered as a result of Your termination of employment, the delivery of Shares shall be delayed until (a) the six-month anniversary of Your separation from service (within the meaning of Section 409A), or (b) if earlier, as soon as practicable following Your death. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option the Committee either may (i) have the Company withhold Shares having a Fair Market Value equal to the amount of the tax withholding or (ii) require You to pay to the Company the amount of the tax withholding.

6. Rights as Shareholder. You will not have any rights of a shareholder prior to the receipt of Your Shares, and will obtain such rights only upon Your receipt of the Shares, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares or cash distributed as dividends with respect to the Shares subject to the RSUs will be subject to the same vesting schedule as the underlying RSUs and shall be settled as provided in Section 5.

7. Clawback. Any RSUs You are granted hereunder and/or Shares you receive in settlement of such RSUs shall be subject to recovery by the Company in the circumstances and manner provided in any Incentive Compensation Clawback Policy that may be adopted or implemented by the Company and in effect from time to time on or after the date hereof, and You shall effectuate any such recovery at such time and in such manner as the Company may specify. For purposes of this Certificate, the term "Incentive Compensation Clawback Policy" means and includes any policy of the type contemplated by Section 10D of the Securities Exchange Act, any rules or regulations of the Securities and Exchange Commission adopted pursuant thereto, or any related rules or listing standards of any national securities exchange or national securities association applicable to the Company.

8. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

9. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

10. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

11. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Code.

12. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

13. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

14. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

15. Entire Understanding. This Certificate and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

16. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada, without reference to principles of conflict of laws.

Electronic Signature: Signed Electronically

Acceptance Date: 09/24/2020

TENET HEALTHCARE 2019 STOCK INCENTIVE PLAN
TERMS AND CONDITIONS OF
RESTRICTED STOCK UNIT PERFORMANCE AWARD

The Human Resources Committee (the "**Committee**") of the Board of Directors of Tenet Healthcare Corporation (the "**Company**") is authorized under the Company's 2019 Stock Incentive Plan, as such may be amended from time to time (the "**Plan**"), to make awards of restricted stock units ("**RSUs**") and to determine the terms of such RSUs.

On **06/02/2020** (the "**Grant Date**"), the Committee granted you, **THOMAS W ARNST** ("**You**"), an award of RSUs. The RSUs were granted by the Committee subject to the terms and conditions set forth below in this certificate (the "**Certificate**"). The RSUs are also subject to the terms and conditions of the Plan, which is incorporated herein by this reference. Each capitalized term not otherwise defined herein will have the meaning given to such term in the Plan.

1. Grant. The Committee has granted You RSUs representing the right to earn 22,615 Shares based upon target achievement of applicable performance goals (the "**Target RSUs**") and up to a maximum of 150% of the Target RSUs in consideration for services to be performed by You for the Company or a Subsidiary of the Company.

2. Performance Period and Criteria.

   a. *Performance Period.* Your RSUs are subject to a three-year performance period that began on January 1, 2020 and ends on December 31, 2022 (the "**Performance Period**").

   b. *Performance Criteria.* Your RSUs will provisionally vest based on the Company's achievement of the performance goals as follows:

      i. Between 0% and 150% of one-third of the Target RSUs will vest based on achievement of the 2020 performance goals set forth set forth in Appendix A for fiscal year 2020;

      ii. Between 0% and 150% of one-third of the Target RSUs will vest based on achievement of the 2021 performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 2021; and

      iii. Between 0% and 150% of one-third of the Target RSUs will vest based on achievement of the 2022 performance goals established by the Committee and communicated to you promptly thereafter for fiscal year 2022.

   c. The performance goals set forth in Appendix A and each of the performance goals established by the Committee for fiscal years 2021 and 2022 shall be collectively referred to herein as the "**Performance Criteria**".

3. Vesting. Subject to Sections 4 and 5 below, the RSUs which have provisionally vested under Section 2 above will vest on **20230228** (the "**Vesting Date**"). Except as otherwise set forth in any written agreement with You or severance plan applicable to You, if Your employment terminates or if You cease providing services to the Company or a Subsidiary for any reason prior to the Vesting Date, other than as set forth in Section 4 or 5 below, Your unvested RSUs (even if provisionally vested) will be automatically cancelled in exchange for no consideration.

4. Certain Terminations. Your unvested RSUs will vest as follows in the event any of the following events (each, a "**Termination Event**") occurs prior to the Vesting Date:

a. Qualifying Termination, Death or Disability (as defined under section 409A(a)(2)(C)(ii) of the Internal Revenue Code): (i) A pro-rated portion (based on the number of months You are actually employed during the Performance Period) of Your RSUs will vest on the date of such a Termination Event based on the Company's actual performance with respect to the applicable Performance Criteria during such completed portion of the Performance Period prior to such a Termination Event and (ii) the remaining portion of Your RSUs will vest on the date of such a Termination Event assuming target achievement of the applicable Performance Criteria for such incomplete portion of the Performance Period following such a Termination Event.

b. Retirement (retirement on or after age 62): A pro-rated portion (based on the number of months You are actually employed during the Performance Period) of Your RSUs will vest on the Vesting Date, taking into account the Company's actual performance with respect to the applicable Performance Criteria.

For purposes hereof, and for the avoidance of doubt, employment by any Tenet Healthcare Corporation consolidated subsidiary or affiliate (collectively, "**Tenet**") will be treated as a continuation of Your employment for all purposes, and You will not be deemed to have experienced a termination of employment as long as You remain continuously employed by any such an employer. Furthermore, in no event will a Qualifying Termination occur as the result of any voluntary resignation (without Good Reason) or solely by reason of a spin-off of Conifer Health Solutions, LLC ("Conifer"), any successor to Conifer, or the assets of Conifer.

5. Change in Control. Except as otherwise set forth in any written agreement with You or severance plan applicable to You, in the event of a Change in Control, the following provisions will apply:

a. If the successor company assumes the RSUs or substitutes other restricted stock units for such RSUs (or agrees to assume or substitute such awards) and you experience a Termination Event within the period beginning on the date that is six (6) months before the occurrence of a Change in Control and ending twenty-four (24) months after the occurrence of a Change in Control, the unvested RSUs (or substitute restricted stock units) will vest as provided in Section 4 above.

b. If the successor company does not assume the RSUs, or substitute other restricted stock units for the RSUs, and if (i) the Change in Control occurs within the Performance Period, then each of the Performance Criteria will be deemed to have been met at the target level and unvested RSUs representing the Target RSUs will fully vest immediately prior to the occurrence of the Change in Control or (ii) the Change in Control occurs after the end of the Performance Period, but prior to the Vesting Date, then Your provisionally vested RSUs will fully vest immediately prior to the occurrence of the Change in Control.

c. In lieu of (a) or (b), the Committee may declare the level at which the Performance Criteria are deemed to be met and the unvested RSUs will vest to that extent immediately prior to the occurrence of the Change in Control.

For purposes of this Section 5, any reference to the "Company" in the definition of "Change in Control" shall be deemed to refer to the "Company or Conifer Health Solutions, LLC" and references to the Board shall be deemed to refer to the Board of Directors of the Company or the Board of Managers of Conifer. Notwithstanding the foregoing, a spin-off of Conifer, any successor to Conifer, or the assets of Conifer shall not give rise to a "Change in Control."

6. Settlement; Tax Withholding. Upon the vesting of Your RSUs, Your RSUs will be settled in Shares within 60 days and You will recognize ordinary income. Notwithstanding the foregoing, to the extent required to comply with Section 409A of the Code, if You are a "specified employee" within the meaning of Section 409A of the Code, and the vesting of Your RSUs is triggered as a result of Your termination of employment, the delivery of Shares shall be delayed until (a) the six-month anniversary of Your separation from service (within the meaning of Section 409A), or (b) if earlier, as soon as practicable following Your death. The Company is required to withhold payroll taxes due with respect to that ordinary income. Pursuant to the Plan, at its option

the Committee either may (i) have the Company withhold Shares having a Fair Market Value equal to the amount of the tax withholding or (ii) require You to pay to the Company the amount of the tax withholding.

7. Rights as Shareholder. You will not have any rights of a shareholder prior to the receipt of Your Shares, and will obtain such rights only upon Your receipt of the Shares, at which time You will have all of the rights of a shareholder with respect to the Shares received upon the vesting of those RSUs, including the right to vote those Shares and receive all dividends and other distributions, if any, paid or made with respect thereto. Any Shares or cash distributed as dividends with respect to the Shares subject to the RSUs will be subject to the same vesting schedule and performance conditions as the underlying RSUs and shall be settled as provided in Section 6.

8. Clawback. Any RSUs You are granted hereunder and/or Shares you receive in settlement of such RSUs shall be subject to recovery by the Company in the circumstances and manner provided in any Incentive Compensation Clawback Policy that may be adopted or implemented by the Company and in effect from time to time on or after the date hereof, and You shall effectuate any such recovery at such time and in such manner as the Company may specify. For purposes of this Certificate, the term "**Incentive Compensation Clawback Policy**" means and includes any policy of the type contemplated by Section 10D of the Securities Exchange Act, any rules or regulations of the Securities and Exchange Commission adopted pursuant thereto, or any related rules or listing standards of any national securities exchange or national securities association applicable to the Company. Until the Company adopts such an Incentive Compensation Clawback Policy, the following clawback provision shall apply to the RSUs:

   In the event that, within three years of the end of the Performance Period, the Company restates its financial results with respect to the Company's performance during the Performance Period due to material non-compliance with any financial reporting requirement under the securities laws as generally applied and the Board of Directors determines Your fraud or misconduct caused or partially caused the need for the restatement, then the Board of Directors shall require You to immediately return to the Company the RSUs or any Shares you receive in settlement of the RSUs or the pre-tax income derived from any disposition of the Shares previously received in settlement of the RSUs (plus a reasonable rate of interest if deemed appropriate by the Board of Directors) that would not have been granted and/or vested, as determined in the sole discretion of the Board, based upon the restated financial results.

9. Transferability. The RSUs generally may not be transferred, assigned or made subject to any encumbrance, pledge, or charge. Limited exceptions to this rule apply in the case of death, divorce, or gift as provided in Section 12.3 of the Plan.

10. Effect on Other Employee Benefit Plans. The value of the RSUs evidenced by this Certificate will not be included as compensation, earnings, salaries, or other similar terms used when calculating Your benefits under any employee benefit plan sponsored by the Company or a Subsidiary, except as such plan otherwise expressly provides.

11. No Employment Rights. Nothing in this Certificate will confer upon You any right to continue in the employ or service of the Company or any Subsidiary or affect the right of the Company or a Subsidiary to terminate Your employment at any time with or without cause.

12. Amendment. By written notice to You, the Committee reserves the right to amend the Plan or the provisions of this Certificate provided that no such amendment will impair in any material respect Your rights under this Certificate without Your consent except as required to comply with applicable securities laws or Section 409A of the Code.

13. Severability. If any term or provision of this Certificate is declared by any court or government authority to be unlawful or invalid, such unlawfulness or invalidity shall not invalidate any term or provision of this Certificate not declared to be unlawful or invalid. Any term or provision of this Certificate so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to such term or provision to the fullest extent possible while remaining lawful and valid.

14. Construction. A copy of the Plan has been made available to You and additional copies of the Plan are available upon request to the Company's Corporate Secretary at the Company's principal executive office during normal business hours. To the extent that any term or provision of this Certificate violates or is inconsistent with an express term or provision of the Plan, the Plan term or provision shall govern and any inconsistent term or provision in this Certificate shall be of no force or effect.

15. Binding Effect and Benefit. This Certificate shall be binding upon and, subject to the terms and conditions hereof, inure to the benefit of the Company, its successors and assigns, and You and Your successors and assigns.

16. Entire Understanding. This Certificate and the Plan embody the entire understanding and agreement of the Company and You in relation to the subject matter hereof, and no promise, condition, representation or warranty, expressed or implied, not herein stated, shall bind the Company or You.

17. Governing Law. This Certificate shall be governed by, and construed in accordance with, the laws of the State of Nevada, without reference to principles of conflict of laws.

Electronic Signature: **Signed Electronically**

Acceptance Date: 09/19/2020

SIXTH AMENDED TENET HEALTHCARE CORPORATION
ANNUAL INCENTIVE PLAN
(As Amended and Restated Effective November 3, 2021)

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 Scheduled Payment 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 Scheduled Payment Date under any circumstances other than those set forth in Subsections (b), (c) or (d) 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 Scheduled Payment 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) on the Scheduled Payment Date, 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 Scheduled Payment Date, such Participant will receive a portion of his/her Award for the Year (or other applicable measurement period) on the Scheduled Payment Date, 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 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.

(d) Exception for Termination of Employment due to Death or Disability. In the event of a Participant's death or Disability, as defined below, before the Scheduled Payment 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 based on the number of full months worked by the Participant for the Company or an Affiliate during such measurement period. The Award under this Section 11(d), will be calculated at the Target Award for the Participant and paid within 60 days of the date of death or Disability. In the event of death of a Participant, the Award will be paid to the estate of the Participant. For purposes of this Section 11(d), a "Disability" or "Disabled" means a condition as a result of which a Participant: i) is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to last for a continuous period of not less than 12 months, or ii) is, by reason of any medically determinable physical or mental impairment that can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, receiving income replacement benefits for a period of not less than three (3) months under an accident and health plan sponsored by the Company or an Affiliate covering the Participant.

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.

Exhibit 21

Consolidated Subsidiaries
of
Tenet Healthcare Corporation
as of December 31, 2021

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
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 Hills Medical Imaging, L.L.C.	California
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

Name of Entity	State or Other Jurisdiction of Formation
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 Diagnostic Imaging Center, LLC	Delaware
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

Name of Entity	State or Other Jurisdiction of Formation
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
Brookwood Women's Diagnostic Center, LLC	Delaware
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
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 GP, Inc.	Florida
CGH Hospital, Ltd.	Florida
Chalon Living, Inc.	Arizona
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

Name of Entity	State or Other Jurisdiction of Formation
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
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
Emerus/BHS SA Hausman, LLC	Texas
Emerus/BHS SA Kelly, LLC	Texas
Emerus/BHS SA, LLC	Texas
Emerus BHS/SA NW Military, LLC	Texas
Emerus/BHS SA Overlook Parkway, LLC	Texas
Emerus/BHS SA Schertz, LLC	Texas
Emerus BHS/SA Southside, LLC	Texas

Name of Entity	State or Other Jurisdiction of Formation
Emerus/BHS SA Thousand Oaks, LLC	Texas
Emerus/BHS SA Westover Hills, LLC	Texas
Enterprise Research Solutions, LLC	Texas
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
HC Hialeah Holdings, Inc.	Florida
HCH Tucson Holdings, LLC	Delaware
HCN Emerus El Paso, LLC	Texas
HCN Emerus Management Sub, LLC	Texas
HCN Emerus Texas, LLC	Texas
HCN EP Horizon City, LLC	Texas
HCN EP Lee Trevino, LLC	Texas

Name of Entity	State or Other Jurisdiction of Formation
HCN EP Northeast, LLC	Texas
HCN EP Sunland Park, 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
Healthcare SMG I, L.L.C.	Florida
Healthcare SMG II, L.L.C.	Florida
Healthcare SMG IV, L.L.C.	Florida
Healthcare UC Holdings, 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 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

Name of Entity	State or Other Jurisdiction of Formation
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
Houston Northwest Partners, Ltd.	Texas
Houston Specialty Hospital, Inc.	Texas
Houston Sunrise Investors, Inc.	Delaware
HSRM International, Inc.	California
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
Magnetic Resonance Imaging of San Luis Obispo, Inc.	California
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
Modesto Radiology Imaging, Inc.	California
Nacogdoches ASC-LP, Inc.	Delaware
National Ancillary, Inc.	Texas

Name of Entity	State or Other Jurisdiction of Formation
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 Imaging Center Holdings, Inc.	Delaware
National Medical Services II, Inc.	Florida
National Outpatient Services 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
Newhope Imaging Center, Inc.	California
New Medical Horizons II, Ltd.	Texas
NICH GP Holdings, LLC	Delaware
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
NSMC Holdings, Inc.	Florida
NS Medical Billing Center, L.L.C.	Florida
NUCH of Georgia, L.L.C.	Georgia
NUCH of Massachusetts, LLC	Massachusetts
NUCH of Michigan, Inc.	Michigan
Okatie Surgical Partners, L.L.C.	South Carolina
Olive Branch Urgent Care #1, LLC	Mississippi

Name of Entity	State or Other Jurisdiction of Formation
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
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 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
Pleasanton Diagnostic Imaging, 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
Pros Temporary Staffing, Inc.	Illinois
PSS Patient Solution Services, LLC	Texas
Republic Health Corporation of Rockwall County	Nevada
Resolute Health Physicians Network, Inc.	Texas

Name of Entity	State or Other Jurisdiction of Formation
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
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

Name of Entity	State or Other Jurisdiction of Formation
South Carolina Health Services, LLC	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
Sun View Imaging, L.L.C.	New Mexico
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
T1 Security, LLC	Texas
Templeton Imaging, Inc.	California
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

Name of Entity	State or Other Jurisdiction of Formation
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 Imaging Services, LLC	California
Turlock Land Company, LLC	California
Twin Cities Community Hospital, Inc.	California
UCC Tucson Holdings, LLC	Delaware
Universal Medical Care Center, L.L.C.	Florida
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

[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.

Name of Entity	State or Other Jurisdiction of Formation
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
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

Name of Entity	State or Other Jurisdiction of Formation
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 Imaging Partners, L.P.	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
Walker Street Imaging Care, Inc.	California
Watermark Physician Services, Inc.	Illinois
West Boca Health Services, L.L.C.	Florida
West Boca Medical Center, Inc.	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
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 Bethesda, LLC	Maryland
Advanced Surgery Center of Metairie, LLC	Louisiana
Advanced Surgery Center of Northern Louisiana, LLC	Louisiana
Advanced Surgery Center of Sarasota, LLC	Florida
Advanced Surgery Center of Tampa, LLC	Florida
Advanced Surgical Care of Lutz, 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
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
Ambulatory Surgical Associates, LLC	Tennessee
Ambulatory Surgical Center of Somerville, LLC	New Jersey
American Institute of Gastric Banding Phoenix, Limited Partnership	Arizona
American Institute of Gastric Banding, Ltd.	Texas
Anesthesia Partners of Gallatin, LLC	Tennessee
APN	Texas
ARC Worcester Center L.P.	Tennessee
Arizona Spine and Joint Hospital, LLC	Arizona
ASC of New Jersey LLC	New Jersey
ASC Old Co., LP	Delaware
Ascension Saint Thomas Lebanon Surgery Center, LLC	Tennessee
ASJH Joint Venture, LLC	Arizona
Atlantic Coast Surgical Suites, LLC	New Hampshire
Atlantic Health-USP Surgery Centers, L.L.C.	New Jersey

Name of Entity	State or Other Jurisdiction of Formation
Audubon Ambulatory Surgery Center, LLC	Colorado
Avita/USP Surgery Centers, L.L.C.	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
Beaumont Surgical Affiliates, Ltd.	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
Braselton Endoscopy Center, LLC	Georgia
Briarcliff Ambulatory Surgery Center, L.P.	Missouri
Bristol Ambulatory Surgery Center, LLC	Tennessee
Brookwood Baptist Health 3, LLC	Delaware
Brownsville Ambulatory Surgery Center, LLC	Texas
Camp Lowell Surgery Center, L.L.C.	Arizona
CareSpot of Austin, LLC	Delaware
CareSpot of Memphis, LLC	Delaware
Carmel Specialty Surgery Center, LLC	Indiana
Castle Rock Surgery Center, LLC	Colorado
Cedar Park Surgery Center, L.L.P.	Texas
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
CHIC/USP Surgery Centers, LLC	Colorado
Chico Surgery Center, L.P.	California
Clarksville Surgery Center, LLC	Tennessee
Coast Surgery Center, L.P.	California
Colorado GI Centers, LLC	Colorado
Compass Surgical Partners Holdings of Asheville, LLC	North Carolina
Compass Surgical Partners Holdings of Odessa, LLC	North Carolina
Compass Surgical Partners Holdings of Raleigh, LLC	North Carolina
Compass Surgical Partners Holdings of St. Petersburg, LLC	North Carolina

Name of Entity	State or Other Jurisdiction of Formation
Compass Surgical Partners Holdings of Tampa, LLC	North Carolina
Compass Surgical Partners Holdings of Waco, LLC	North Carolina
Compass Surgical Partners Holdings of Winston-Salem, LLC	North Carolina
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 Surgery Center, L.P.	Missouri
Crown Point Surgery Center, LLC	Colorado
CS/USP General Partner, LLC	Texas
CS/USP Surgery Centers, LP	Texas
Delray Beach ASC, LLC	Florida
Denville Surgery Center, LLC	New Jersey
Desert Ridge Outpatient Surgery, LLC	Arizona
Desoto Surgicare Partners, Ltd.	Texas
Destin Surgery Center, LLC	Florida
DeTar/USP Surgery Center, LLC	Texas
DH/USP SJOSC Investment Company, L.L.C.	Arizona
Dignity/USP Phoenix Surgery Centers II, LLC	Arizona
Doctors Outpatient Surgery Center of Jupiter, L.L.C.	Florida
East Atlanta Endoscopy Centers, LLC	Georgia
East West Surgery Center, L.P.	Georgia
Eastgate Building Center, L.L.C.	Ohio
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
Encinitas Endoscopy Center, 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
Fort Worth Hospital Real Estate, LP	Texas
Foundation Bariatric Hospital of San Antonio, LLC	Texas
Foundation San Antonio Borrower Sub, LLC	Texas
Franklin Endo UAP, LLC	Tennessee
Franklin Endoscopy Center, LLC	Tennessee

Name of Entity	State or Other Jurisdiction of Formation
Frontenac Ambulatory Surgery & Spine Care Center, L.P.	Missouri
GAB Endoscopy Center, LLC	Texas
Gainesville Endoscopy Center, LLC	Georgia
Gainesville Endoscopy ASC, LLC	Georgia
Gamma Surgery Center, LLC	Delaware
GCSA Ambulatory Surgery Center, LLC	Texas
Georgia Endoscopy Center, LLC	Georgia
Georgia Musculoskeletal Network, Inc.	Georgia
GIA/USP Surgery Centers, LLC	Delaware
Glen Echo Surgery Center, LLC	Maryland
Golden Ridge ASC, LLC	Colorado
Great Lakes Surgical Suites, LLC	Indiana
Greenville Physicians Surgery Center, LLP	Texas
Greenwood ASC, LLC	Delaware
Hagerstown Surgery Center, LLC	Maryland
Harbor Heights Surgery Center, LLC	Maryland
Harvard Park Surgery Center, LLC	Colorado
Haymarket Surgery Center, LLC	Virginia
Health Horizons of Kansas City, Inc.	Tennessee
Health Horizons of Murfreesboro, Inc.	Tennessee
Health Horizons/Piedmont Joint Venture, LLC	Tennessee
Healthmark Partners, Inc.	Delaware
Hill Country ASC Partners, LLC	Texas
Hill Country Surgery Center, LLC	Texas
HKRI Holdings, LLC	North Carolina
HMHP/USP Surgery Centers, LLC	Ohio
Holston Valley Ambulatory Surgery Center, LLC	Tennessee
Houston PSC, L.P.	Texas
HSS Palm Beach Ambulatory Surgery Center, LLC	Florida
HSS/USP Surgery Center, LLC	Florida
Hyde Park Surgery Center, LLC	Texas
Intracoastal Surgery Center, LLC	Florida
Jacksonville Endoscopy Centers, LLC	Florida
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
Lancaster Specialty Surgery Center, LLC	Ohio
Lebanon Endoscopy Center, LLC	Tennessee
Legacy Warren Partners, L.P.	Texas

Name of Entity	State or Other Jurisdiction of Formation
Leonardtown Surgery Center, LLC	Maryland
Longleaf Surgery Center, LLC	Florida
Lubbock ASC Holding Co, LLC	Texas
Magnolia Surgery Center Limited Partnership	Delaware
Manchester Ambulatory Surgery Center, LP	Missouri
Maple Lawn Surgery Center, LLC	Maryland
Marion Surgery Center, LLC	Florida
MASC Partners, LLC	Missouri
Mason Ridge Ambulatory Surgery Center, L.P.	Missouri
McLaren ASC of Flint, LLC	Michigan
Medical House Staffing, 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 Kingsland, L.L.C.	Texas
Memorial Hermann Surgery Center Kirby, LLC	Texas
Memorial Hermann Surgery Center Main Street, LLC	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 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 IV, LLP	Texas
Memorial Hermann West Houston Surgery Center, LLC	Texas
Memorial Surgery Center, LLC	Oklahoma
Metro Specialty Surgery Center, LLC	Indiana
Metro Surgery Center, LLC	Delaware
Metropolitan Medical Partners, LLC	Maryland
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

Name of Entity	State or Other Jurisdiction of Formation
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
Miami Surgical Suites, LLC	Florida
Mid Rivers Ambulatory Surgery Center, L.P.	Missouri
Mid-State Endoscopy Center, LLC	Tennessee
Mid State Endo UAP, LLC	Tennessee
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
Minimally Invasive Surgicenter LLC	Florida
Minimally Invasive Surgicenter of Delray, LLC	Florida
Monocacy Surgery Center, LLC	Maryland
Mountain Empire Surgery Center, L.P.	Georgia
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 Surgery Center Holdings, Inc.	Delaware
New Horizons Surgery Center, LLC	Ohio
NKCH/USP Briarcliff GP, LLC	Missouri
NKCH/USP Liberty GP, LLC	Missouri
NKCH/USP Surgery Centers II, L.L.C.	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 Denver Musculoskeletal Surgical Partners, LLC	Colorado
North Haven Surgery Center, LLC	Connecticut
North Shore Same Day Surgery, L.L.C.	Illinois
North Shore Surgical Suites, LLC	Wisconsin
NorthPointe Surgical Suites, LLC	Ohio
Northridge Surgery Center, L.P.	Tennessee

Name of Entity	State or Other Jurisdiction of Formation
NorthShore/USP Surgery Centers II, L.L.C.	Illinois
Northwest Georgia Orthopaedic Surgery Center, LLC	Georgia
Northwest Regional ASC, LLC	Delaware
Northwest Regional Surgery Center, LLC	Indiana
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
NSN Revenue Resources, LLC	Florida
The Old Bridge Surgery Center, LLC	Delaware
Old Tesson Surgery Center, L.P.	Missouri
Olive Ambulatory Surgery Center, LLC	Missouri
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/New Mexico ASC, Inc.	Georgia
The Outpatient Center, LLC	Florida
Oxford Ambulatory Surgery Center, LLC	Connecticut
Pacific Endoscopy and Surgery Center, LLC	California
Pacific Endo-Surgical Center, L.P.	California
PAHS/USP Surgery Centers, LLC	Colorado
Palm Beach International Surgery Center, LLC	Florida
ParkCreek ASC, LLC	Florida
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
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
Piccard Surgery Center, LLC	Maryland
Piedmont ASC, LLC	North Carolina

Name of Entity	State or Other Jurisdiction of Formation
Point of Rocks Surgery Center, LLC	Maryland
Porter Musculoskeletal Surgery Center, LLC	Colorado
Potomac View Surgery Center, LLC	Maryland
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
Red Cedar Surgery Center, LLC	Michigan
Redmond Surgery Center, LLC	Tennessee
Resurgens Surgery Center, LLC	Georgia
Riva Road Surgery Center, LLC	Maryland
River North Same Day Surgery, L.L.C.	Illinois
Riverside Ambulatory Surgery Center, LLC	Missouri
Rock Hill Surgery Center, LLC	South Carolina
Rockville Surgical Suites, LLC	Maryland
Rocky Mountain Endoscopy Centers, LLC	Colorado
Roswell Surgery Center, L.L.C.	Georgia
Safety Harbor ASC Company, LLC	Florida
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 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

Name of Entity	State or Other Jurisdiction of Formation
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/USP Surgery Centers 2, LLC	California
SCNRE, LLC	Texas
Scottsdale Endoscopy ASC, LLC	Arizona
Seaside Surgery Center, LLC	Florida
Shore Outpatient Surgicenter, L.L.C.	Georgia
Shoreline Real Estate Partnership, LLP	Texas
Shoreline Surgery Center, LLP	Texas
Sierra Vista Surgery Center, LLC	California
Silver Cross Ambulatory Surgery Center, LLC	Illinois
Silver Cross/USP Surgery Centers, LLC	Illinois
SLPA ACO, LLC	Missouri
Solantic Development, LLC	Delaware
Solantic Holdings Corporation	Delaware
South County Outpatient Endoscopy Services, L.P.	Missouri
South Denver Musculoskeletal Surgical Partners, LLC	Colorado
South Florida Ambulatory Surgical Center, LLC	Florida
South Plains Endoscopy Associates, LLC	Texas
Southeast Ohio Surgical Suites, LLC	Ohio
The Southeastern Spine Institute Ambulatory Surgery Center, L.L.C.	South Carolina
Southwest Endoscopy, LLC	Arizona
Southwestern Ambulatory Surgery Center, LLC	Pennsylvania
Specialty Surgicenters, Inc.	Georgia
SSI Holdings, Inc.	Georgia
St. Augustine Endoscopy Center, LLC	Florida
St. Joseph’s Outpatient Surgery Center, LLC	Arizona
St. Louis Physician Alliance, LLC	Missouri
St. Louis Surgical Center, LC	Missouri
St. Louis Urology Center, LLC	Missouri
St. Luke’s/USP Surgery Centers, LLC	Missouri
St. Vincent Health/USP, LLC	Indiana
St. Vincent/USP Surgery Centers, LLC	Arkansas
Suburban Endoscopy Center, LLC	New Jersey
Summit View Surgery Center, LLC	Colorado
SurgCenter at Paradise Valley, LLC	Arizona
SurgCenter Camelback, LLC	Arizona
SurgCenter Clearwater, LLC	Florida

Name of Entity	State or Other Jurisdiction of Formation
SurgCenter Northeast, LLC	Florida
SurgCenter of Deer Valley, LLC	Arizona
SurgCenter of Glen Burnie, LLC	Maryland
SurgCenter of Greater Dallas, LLC	Texas
SurgCenter of Greater Jacksonville, LLC	Florida
SurgCenter of Northern Baltimore, LLC	Maryland
SurgCenter of Palm Beach Gardens, LLC	Florida
SurgCenter of Pine Ridge, LLC	Florida
SurgCenter of Silver Spring, LLC	Maryland
SurgCenter of Southern Maryland, LLC	Maryland
SurgCenter of St. Lucie, LLC	Florida
SurgCenter of the Potomac, LLC	Maryland
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
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 Santa Barbara, LLC	California
Surgery Center of Scottsdale, LLC	Oklahoma
Surgery Centers of America II, L.L.C.	Oklahoma
Surgery Centre of SW Florida, LLC	Florida
Surgical Center Development #3, LLC	Nevada
Surgical Center Development #4, LLC	Nevada
Surgical Elite of Avondale, L.L.C.	Arizona
Surgical Health Partners, LLC	Tennessee
Surgical Institute Management, LLC	Pennsylvania
Surgical Institute of Reading, LLC	Pennsylvania
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
Tampa Bay Joint and Spine, LLC	Florida

Name of Entity	State or Other Jurisdiction of Formation
Tempe New Day Surgery Center, LP	Arizona
TENN SM, LLC	Tennessee
Terre Haute Surgical Center, LLC	Indiana
Teton Outpatient Services, LLC	Wyoming
Texan Ambulatory Surgery Center, L.P.	Texas
Texas Orthopedics Surgery Center, LLC	Texas
Theda Oaks Gastroenterology & Endoscopy Center, LLC	Texas
Three Springs ASC, LLC	Colorado
Timonium Surgery Center, LLC	Maryland
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
TOSCA ASC Holdings, LLC	Delaware
TOPS Specialty Hospital, Ltd.	Texas
Treasure Coast ASC, LLC	Florida
The Tresanti Surgical Center, LLC	California
Trinity Health of New England/USP Surgery Centers, L.L.C.	Connecticut
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
Twin Cities Ambulatory Surgery Center, L.P.	Missouri
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

Name of Entity	State or Other Jurisdiction of Formation
UAP of Tennessee, Inc.	Tennessee
UAP of Texas, Inc.	Texas
UAP Scopes, LLC	Missouri
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
Upper Bay Surgery Center, LLC	Maryland
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

Name of Entity	State or Other Jurisdiction of Formation
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 Jacksonville, Inc.	Florida
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

Name of Entity	State or Other Jurisdiction of Formation
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

Name of Entity	State or Other Jurisdiction of Formation
Utica/USP Tulsa, L.L.C.	Oklahoma
Valley Baptist Surgery Center, LLC	Texas
Valley Baptist Surgery Center Real Estate, LLC	Texas
Ventana Surgical Center, LLC	California
Veroscan, Inc.	Delaware
Victoria Ambulatory Surgery Center, L.P.	Delaware
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
Wilmington Endoscopy Center, LLC	North Carolina
Windsor Mill Surgery Center, LLC	Maryland
Winter Haven Ambulatory Surgical Center, L.L.C.	Florida
Wisconsin Specialty Surgery Center, LLC	Wisconsin
Wymark Surgery Center, LLC	California

Exhibit 23

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 18, 2022, 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, 2021.

/s/ Deloitte & Touche LLP
Dallas, Texas
February 18, 2022

Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Saumya Sutaria, 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 18, 2022

/s/ SAUMYA SUTARIA

Saumya Sutaria, M.D.

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 18, 2022

/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 Saumya Sutaria and Daniel J. Cancelmi, being, respectively, the 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, 2021 (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 18, 2022 /s/ SAUMYA SUTARIA

Saumya Sutaria, M.D.
Chief Executive Officer

Date: February 18, 2022 /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.