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, 2018**

OR

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

Commission File Number 1-7293

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

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

1445 Ross Avenue, Suite 1400
Dallas, TX 75202
(Address of principal executive offices, including zip code)

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

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

Title of each class	Name of each exchange on which registered
Common stock, $0.05 par value	New York Stock Exchange
6.875% Senior Notes due 2031	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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, 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 ☐

Emerging growth company ☐

Smaller reporting 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 is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

As of June 30, 2018, 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 $2.3 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on Friday, June 29, 2018. As of January 31, 2019, there were 102,667,337 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2019 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

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PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a national, diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks, primarily in large urban and suburban markets. Through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI"), at December 31, 2018 , we operated 68 hospitals (three of which we have since divested), 23 surgical hospitals and approximately 475 outpatient centers throughout the United States. In addition, our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other, Ambulatory Care and Conifer. Additional information about our business segments is provided below; statistical data for the segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

The healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA"). It is difficult to predict the full impact of regulatory uncertainty on our future revenues and operations. In addition, we believe that several key trends are shaping 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 industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (4) consolidation continues across the entire healthcare sector. Our ability to execute on our strategies and respond to these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. For information about our strategies, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. 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.

We are focused on improving operational effectiveness, increasing capital efficiency and margins, expanding patient access points, enhancing the customer care experience in every part of our operations, and growing our higher-acuity inpatient service lines, as well as aligning service line growth with community demand. We believe our inpatient admissions have been constrained in recent years 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 are experiencing higher growth rates than traditional Medicare plans, and contracting strategies that create shared value with payers should help us grow our patient volumes over time.

We continue to exit service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. To that end, in 2018 we divested eight hospitals in the United States, as well as all of our operations in the United Kingdom. In addition, in January 2019, we completed the previously announced sale of three hospitals in the Chicago area that we owned at December 31, 2018. 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 generation and lower our ratio of debt-to-Adjusted EBITDA.

We also remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We opened eight new outpatient centers in the year ended December 31, 2018, and we acquired 10 outpatient businesses, including two surgical hospitals . We believe USPI's surgery centers 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. We have also continued to grow our imaging and urgent care businesses through USPI to reflect our broader strategies to (1) offer more services to patients, (2) broaden the

capabilities we offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

In addition to providing revenue cycle management services to healthcare 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. At December 31, 2018, Conifer served approximately 750 Tenet and non-Tenet hospital and other clients nationwide. As previously announced, we are exploring strategic alternatives for Conifer. There can be no assurance that this process will result in a consummated transaction.

We have also undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions (including streamlining corporate overhead and centralized support functions), the renegotiation of contracts with suppliers and vendors, and the consolidation of office locations. In 2019, we are continuing to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing certain functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses— At December 31, 2018 , our subsidiaries operated 68 hospitals, including one children's hospital, two specialty hospitals and one critical access hospital, serving primarily urban and suburban communities in 10 states. (Following the sale of our Chicago-area hospitals and related operations effective January 28, 2019, our subsidiaries operated 65 hospitals in nine states.) Our subsidiaries had sole ownership of 57 of the hospitals we operated at December 31, 2018, nine were owned or leased by entities that are, in turn, jointly owned by a Tenet subsidiary and a healthcare system partner, and two were owned by third parties and leased by our wholly owned subsidiaries. Our Hospital Operations and other segment also included 165 outpatient centers at December 31, 2018, the majority of which are freestanding urgent care centers, provider-based diagnostic imaging centers, off-campus emergency departments and provider-based ambulatory surgery centers. In addition, at December 31, 2018, 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 740 physician practices; accountable care organizations and clinically integrated networks; and other ancillary healthcare businesses.

Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: (1) changes in federal and state healthcare regulations; (2) the business environment, economic conditions and demographics of local communities in which we operate; (3) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (4) seasonal cycles of illness; (5) climate and weather conditions; (6) physician recruitment, retention and attrition; (7) advances in technology and treatments that reduce length of stay; (8) local healthcare competitors; (9) managed care contract negotiations or terminations; (10) the number of patients with high-deductible health insurance plans; (11) hospital performance data on quality measures and patient satisfaction, as well as standard charges for our services; (12) any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and (13) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most have intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals provide tertiary care services, such as cardiothoracic surgery, neonatal intensive care and neurosurgery, and some also offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Our children's hospital provides tertiary and quaternary pediatric services, including organ and bone marrow transplants, as well as burn services. Moreover, a number of our hospitals offer advanced treatment options for patients, including limb-salvaging vascular procedures, acute level 1 trauma services, comprehensive intravascular stroke care, minimally invasive cardiac valve replacement, cutting edge imaging technology, and telemedicine access for selected medical specialties.

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

The table below 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, 2018:

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	221	Owned
Abrazo Scottsdale Campus	Phoenix	136	Owned
Abrazo West Campus	Goodyear	188	Owned
Holy Cross Hospital (4)(5)	Nogales	25	JV/Owned
St. Joseph's Hospital (4)	Tucson	486	JV/Owned
St. Mary's Hospital (4)	Tucson	400	JV/Owned
California			
Desert Regional Medical Center (6)	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital and Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center (7)	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	163	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center (8)	San Ramon	123	JV/Owned
Sierra Vista Regional Medical Center	San Luis Obispo	162	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	536	Owned
Florida Medical Center – a campus of North Shore	Lauderdale Lakes	459	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	337	Owned
Palm Beach Gardens Medical Center	Palm Beach Gardens	199	Owned
Palmetto General Hospital	Hialeah	368	Owned
St. Mary's Medical Center	West Palm Beach	460	Owned
West Boca Medical Center	Boca Raton	195	Owned
Illinois			
Louis A. Weiss Memorial Hospital (9)	Chicago	236	Owned
Westlake Hospital (9)	Melrose Park	230	Owned
West Suburban Medical Center (9)	Oak Park	234	Owned

Hospital	Location	Licensed Beds	Status
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	147	Owned
MetroWest Medical Center – Leonard Morse Campus	Natick	160	Owned
Saint Vincent Hospital	Worcester	283	Owned
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	273	Owned
Harper University Hospital	Detroit	470	Owned
Huron Valley-Sinai Hospital	Commerce Township	158	Owned
Hutzel Women's Hospital	Detroit	114	Owned
Rehabilitation Institute of Michigan (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	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	479	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
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	297	Owned
The Hospitals of Providence Transmountain Campus	El Paso	106	Owned
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	161	Owned
North Central Baptist Hospital	San Antonio	429	Owned
Northeast Baptist Hospital	San Antonio	371	Owned
Resolute Health Hospital	New Braunfels	128	Owned
St. Luke's Baptist Hospital	San Antonio	287	Owned
Valley Baptist Medical Center	Harlingen	586	Owned
Valley Baptist Medical Center – Brownsville	Brownsville	243	Owned
Total Licensed Beds		**17,937**	

(1) Operated by a limited liability company formed as part of a joint venture with Baptist Health System, Inc. ("BHS"), a not-for-profit healthcare system in Alabama; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2018, and BHS owned a 40% interest.

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

(3) Specialty hospital.

(4) Owned by a limited liability company formed as part of a joint venture with Dignity Health and Ascension Arizona, each of which is a not-for-profit healthcare system; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2018, Dignity Health owned a 22.5% interest and Ascension Arizona owned a 17.5% interest.

(5) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital.

(6) Lease expires in May 2027.

(7) Lease expires in July 2045.

(8) Owned by a limited liability company formed as part of a joint venture with John Muir Health ("JMH"), a not-for-profit healthcare system in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the entity at December 31, 2018, and JMH owned a 49% interest.

(9) We sold our Chicago-area hospitals and related operations effective January 28, 2019.

Information regarding the utilization of licensed beds and other operating statistics at December 31, 2018, 2017 and 2016 can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

At December 31, 2018, our Hospital Operations and other segment also included 50 diagnostic imaging centers, 12 off-campus emergency departments, 11 ambulatory surgery centers and one urgent care center operated as departments of our hospitals and under the same license, as well as 91 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of six diagnostic imaging centers, eight emergency facilities (seven of which are licensed as microhospitals), two ambulatory surgery centers and 75 urgent care centers. Nearly all of our freestanding urgent care centers are managed by USPI and operated under our national MedPost brand. Over half of the outpatient centers in our Hospital Operations and other segment at December 31, 2018 were in California, Florida and Texas, the same states where we had the largest concentrations of licensed hospital beds. Strong concentrations of hospital beds and outpatient centers within market areas may help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Accountable Care Organizations and Clinically Integrated Networks— We own, control or operate five accountable care organizations ("ACOs") and 10 clinically integrated networks ("CINs") – in Alabama, Arizona, California, Florida, Massachusetts, Michigan, Missouri, Tennessee and Texas – and participate in four additional ACOs and CINs with other healthcare providers for select markets in Arizona and Texas. 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. Both ACOs and CINs operate using a range of payment and care coordination models.

Health Plans— We previously announced our intention to sell or otherwise dispose of our health plan businesses because they are not a core part of our long-term growth strategy. To that end, we sold, divested the membership of or discontinued four health plans in 2017 and, in 2018, we divested our Chicago-based preferred provider network and our Southern California Medicare Advantage plan. Health plans we have not sold outright are being wound-down; however, during this time, they continue to be subject to numerous federal and state statutes and regulations related to their business operations, and each such health plan continues to be licensed by one or more agencies in the states in which they conduct business. In addition, insurance regulations in the states in which we currently operate have required us to maintain cash reserves in connection with certain health plans throughout the wind-down process.

AMBULATORY CARE SEGMENT

Our Ambulatory Care segment is comprised of the operations of USPI and included nine facilities in the United Kingdom until their divestiture in August 2018. At December 31, 2018, USPI had interests in 255 ambulatory surgery centers, 36 urgent care centers operated under the CareSpot brand, 23 imaging centers and 23 surgical hospitals in 27 states. Of these 337 facilities, 208 are jointly owned with healthcare systems. At December 31, 2018, we owned approximately 95% of USPI, and Baylor University Medical Center ("Baylor") owned approximately 5%.

Operations of USPI— USPI acquires and develops its facilities primarily through the formation of joint ventures with physicians and healthcare 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. We believe that this acquisition and development strategy and operating model will enable USPI to continue to grow because of various industry trends we have seen emerge in recent years, namely that: (1) consumers are increasingly selecting services and providers based on cost and convenience, as well as quality; (2) more procedures are shifting from inpatient to outpatient settings; and (3) healthcare providers are entering into joint ventures to maximize effectiveness, reduce costs and build clinically integrated networks.

USPI's surgical facilities primarily specialize in non-emergency cases. We believe surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability and convenience. Medical emergencies at acute care hospitals often demand the unplanned use of operating rooms and result in the postponement or delay of scheduled surgeries, disrupting physicians' practices and inconveniencing patients. Outpatient facilities generally

provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases. In addition, many physicians choose to perform surgery in outpatient facilities because their patients prefer the comfort of a less institutional atmosphere and the convenience of simplified admissions and discharge procedures.

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

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

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

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, 2018, we owned 76.2% of Conifer Health Solutions, LLC, and Catholic Health Initiatives ("CHI") had a 23.8% ownership position. We have been exploring strategic alternatives for Conifer, including a potential sale or merger, a tax-efficient spin-off or a combination of alternative transactions. There can be no assurance that this process will result in a consummated transaction, and we may ultimately decide to retain all or part of Conifer's business.

Services— Conifer provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

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 under the ACA; (2) clinical revenue integrity solutions, including: clinical admission reviews; coding; clinical documentation improvement; coding compliance audits; charge description master management; and health information services; and (3) accounts receivable management solutions, including: third-party billing and collections; denials management; and patient collections. All of these solutions include ongoing measurement and monitoring of key revenue cycle metrics, as well as productivity and quality improvement programs. These revenue cycle management solutions assist hospitals, physician practices and other healthcare organizations in improving cash flow, revenue, and physician and patient satisfaction.

In addition, Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referral requests, calls regarding maternity services and other patient inquiries, (2) community education and

outreach, and (3) scheduling and appointment reminders. Additionally, Conifer coordinates and implements marketing outreach programs to keep patients informed of screenings, seminars and other events and services.

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

Clients— At December 31, 2018, Conifer provided one or more of the business process services described above to approximately 750 clients nationwide. Tenet and CHI facilities represented over 300 of these clients, and the remainder were unaffiliated healthcare systems, hospitals, physician practices, self-insured organizations, health plans and other entities. The agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer, were initially scheduled to expire in December 2018. As we continue to pursue strategic alternatives for Conifer, these agreements were renewed for an additional year with substantially similar pricing terms; however, the pricing or other material terms of such agreements may be modified if any such strategic alternative is consummated. Conifer's agreement with CHI to provide patient access, revenue integrity and patient financial services to CHI's facilities expires in 2032. For the year ended December 31, 2018, approximately 38% of Conifer's net operating revenues were attributable to its relationship with Tenet and approximately 36% were attributable to its relationship with CHI. Additional information about our Conifer operating segment can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

As we explore a sale or other strategic alternatives for Conifer, we are continuing to market Conifer's revenue cycle management, patient communications and engagement services, and value-based care solutions businesses. The uncertainty regarding our plans for Conifer may have an adverse impact on our ability to secure new clients for Conifer. However, 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; (4) leveraging data from tens of millions of patient interactions for continued enhancement of the value-based care environment to drive competitive differentiation; and (5) developing services for our Ambulatory Care segment, leveraging USPI's capabilities. There can be no assurance that Conifer will be successful in generating new client relationships, particularly with respect to hospitals we or Conifer's other 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.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2018 are set forth in the table beginning on page 3. We lease the majority of our outpatient facilities in both our Hospital Operations and other segment and our Ambulatory Care segment. These leases typically have initial terms ranging from five to 20 years, and most of the leases contain options to extend the lease periods. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own many of these medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

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

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. However, third parties may develop intellectual property that is similar or superior to ours. We also license third-party software, other technology and certain trademarks through agreements that impose certain restrictions on our ability to use the licensed items. We control access to and use of our software and other technology

through a combination of internal and external controls. Although we do not believe the intellectual property we utilize infringes any intellectual property right held by a third party, we could be prevented from utilizing such property and could be subject to significant damage awards if our use is found to do so.

PHYSICIANS AND EMPLOYEES

Physicians— Our operations depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and 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, 2018, we owned over 740 physician practices, and we employed (where permitted by state law) or otherwise affiliated with nearly 1,600 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals and outpatient centers. It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Moreover, our ability to recruit and employ physicians is closely regulated.

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

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, 2018, approximately 26% of the employees in our Hospital Operations and other segment were represented by labor unions. Less than 1% of the employees in our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 35 of our hospitals, the majority of which are in California, Florida and Michigan. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is a possibility that strikes could occur, and our continued operation during any strikes could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods, which could result in increases in salaries, wages and benefits expense.

Headcount— At December 31, 2018, we employed approximately 115,500 people (of which approximately 22% were part-time employees) in our three business segments, as follows:

Hospital Operations and other	85,010
Ambulatory Care	17,710
Conifer	12,780
Total	**115,500**

COMPETITION

HEALTHCARE SERVICES

Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, our competitors (1) may offer a broader array of services or more desirable facilities to patients and physicians than ours, (2) may have larger or

more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, (4) may be more centrally located with better parking or closer proximity to public transportation or (5) may be able to negotiate more favorable reimbursement rates that they may use to strengthen their competitive position. In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies, as well as health insurers and private equity companies seeking to acquire providers, in specific geographic markets.

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

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

In addition, the competitive positions of hospitals and outpatient facilities depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of those facilities, as well as physicians who affiliate with and use outpatient centers as an extension of their practices. 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. State laws that require findings of need for construction and expansion of healthcare facilities or services (as described in "Healthcare Regulation and Licensing – Certificate of Need Requirements" below) may also impact competition.

Our strategies are designed to help our hospitals and outpatient facilities remain competitive. We believe emphasis on higher-demand clinical service lines (including outpatient lines) and improved quality metrics will improve our volumes. Furthermore, we have expanded our ambulatory care business, and 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 have also sought to include all of our hospitals and other healthcare businesses in the related geographic area or nationally when negotiating new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks.

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

Moreover, in most of our markets, we have formed clinically integrated networks, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure

or other risk-sharing model. However, we do face competition from other healthcare systems that are implementing similar physician alignment strategies, such as employing physicians, acquiring physician practice groups, and participating in ACOs or other clinical integration models.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Our Conifer subsidiary faces competition from existing participants and new entrants to the revenue cycle management market, some of which may have significantly greater capital resources than Conifer. In addition, the internal revenue cycle management staff of hospitals and other healthcare providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions may choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, 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 uncertainty regarding our plans for Conifer may have an adverse impact on Conifer's ability to secure new clients.

HEALTHCARE REGULATION AND LICENSING

HEALTHCARE REFORM

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

The initial expansion of health insurance coverage under the ACA resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as 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 President issued an executive order in January 2017 declaring that it is the official policy of his administration to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations. In October 2017, the administration announced that reimbursements to insurance companies for ACA cost-sharing

reduction ("CSR") plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, many insurers increased premiums for plans offered on ACA exchanges and a few withdrew entirely from offering plans on some of the exchanges. In addition, in December 2017, Congress passed and the President signed a tax reform bill into law that, among other things, eliminates the ACA's individual mandate penalty for not buying health insurance starting in 2019. The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that eliminating the mandate penalty starting in 2019 – and making no other changes to the then-current law – would cause the number of people with health insurance to decrease by 4 million in 2019 and 13 million in 2027. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. We cannot predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

There have also been successful judicial challenges to the ACA, including a December 2018 ruling by the U.S. District Court for the Northern District of Texas that the ACA's individual mandate is unconstitutional. Because the judge's order was stayed pending appeal, the decision's near-term impact on health insurance coverage under the ACA may be limited; however, uncertainty over the future of the ACA has intensified. The ultimate outcome of this decision and other judicial challenges is indeterminate. We are also unable to predict the impact of administrative, regulatory and legislative changes, and market reactions to those changes, on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in Medicare reimbursement and reductions in Medicare disproportionate share hospital ("DSH") payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions scheduled to take effect in federal fiscal years 2020 through 2025) are made.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Anti-Kickback Statute— Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute") prohibit certain business practices and relationships that might affect the provision and cost of healthcare services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other 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 to offer or transfer anything of value to Medicare or Medicaid beneficiaries that is likely to influence their decision to obtain covered goods or services from one provider or service over another. Many states have statutes similar to the federal Anti-kickback Statute, except that the state statutes usually apply to referrals for services reimbursed by all third-party payers, not just federal programs.

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

Stark Law— The Stark law generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined "designated health services," such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services; the prohibition does not apply to health services provided by an ambulatory surgery center if those services are included in the surgery center's composite Medicare payment rate. However, if the ambulatory surgery center is separately billing Medicare for designated health services that are not covered under the ambulatory surgery center's composite Medicare payment rate, or if either the ambulatory surgery center or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ambulatory surgery center service, the Stark law's self-referral prohibition would apply and such services could implicate the Stark law. Exceptions to the Stark law's referral prohibition cover a broad range of common financial relationships. These statutory and the subsequent regulatory exceptions are available to protect certain permitted employment relationships, relocation arrangements, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

The Affordable Care Act also made changes to the "whole hospital" exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in 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, 2018, 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 ambulatory surgery centers in our Ambulatory Care segment, which are owned by joint ventures with physicians or healthcare systems, are subject to the Anti-kickback Statute and, in certain circumstances, may be subject to the Stark law. In addition, we have contracts with physicians and non-physician referral services providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements, such as medical director agreements. We have also provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-kickback Statute, the Stark law, billing requirements, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. For example, we cannot predict whether physicians may ultimately be restricted from holding ownership interests in hospitals or whether the exception relating to services provided by ambulatory surgery centers could be eliminated. We are continuing to enter into new financial arrangements with physicians and other providers in a manner we believe complies 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 healthcare system partners a right to terminate their relationships with us; and any similar determination with respect to Conifer or any of its subsidiaries could give Conifer's clients the right to terminate their services agreements with us. Moreover, any violations by and resulting penalties or exclusions imposed upon USPI's healthcare system 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.

Retention of Independent Compliance Monitor— In September 2016, the Company and certain of its subsidiaries, including Tenet HealthSystem Medical, Inc. ("THSMI"), Atlanta Medical Center, Inc. ("AMCI") and North Fulton Medical Center, Inc. ("NFMCI"), executed agreements with the U.S. Department of Justice ("DOJ") and others to resolve a civil qui tam action and criminal investigation. In accordance with the terms of the resolution agreements, THSMI entered into a Non-Prosecution Agreement (as amended, the "NPA") with the Criminal Division, Fraud Section, of the DOJ and the U.S. Attorney's Office for the Northern District of Georgia (together, the "Offices"). The NPA requires, among other things, (1) THSMI and the Company to fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, and (2) the Company to retain an independent compliance monitor to assess, oversee and monitor its compliance with the obligations under the NPA. The powers, duties and responsibilities of the independent compliance monitor are broadly defined. On February 1, 2017, the Company retained two independent co-monitors (the "Monitor"), who are partners in a national law firm.

The Monitor's primary responsibility is to assess, oversee and monitor the Company's compliance with its obligations under the NPA to specifically address and reduce the risk of any recurrence of violations of the Anti-kickback Statute and Stark law by any entity the Company owns, in whole or in part. In doing so, the Monitor reviews and monitors the effectiveness of the Company's compliance with the Anti-kickback Statute and the Stark law, as well as respective implementing regulations, advisories and advisory opinions promulgated thereunder, and makes such recommendations as the Monitor believes are necessary to comply with the NPA. With respect to all entities in which the Company or one of its affiliates owns a direct or indirect equity interest of 50% or less and does not manage or control the day-to-day operations, the Monitor's access to such entities is co-extensive with the Company's access or control and for the purpose of reviewing the conduct. During its term, the Monitor will review and provide recommendations for improving compliance with the Anti-kickback Statute and Stark law, as well as the design, implementation and enforcement of the Company's compliance and ethics programs for the purpose of preventing future criminal and ethical violations by the Company and its subsidiaries, including, but not limited to, violations related to the conduct giving rise to the NPA and the Criminal Information filed in connection with the NPA. If we are alleged or found to have violated the terms of the NPA described above or federal healthcare laws, rules or regulations in the future, our business, financial condition, results of operations or cash flows could be materially adversely affected. For additional information regarding the duties and authorities of the Monitor, reference is made to our Current Report on Form 8-K filed with the U.S. Securities and Exchange Commission ("SEC") on October 3, 2016.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

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

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

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

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

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

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

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

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

HEALTHCARE FACILITY LICENSING REQUIREMENTS

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

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

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

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

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates or determinations of need, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Our subsidiaries operate hospitals in six states that require a form of state approval under certificate of need programs applicable to those hospitals. Approximately 71% of our licensed hospital beds are located in these states (namely, Alabama, Florida, Massachusetts, Michigan, South Carolina and Tennessee). The certificate of need programs in most of these states, along with several others, also apply to ambulatory surgery centers.

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

ENVIRONMENTAL MATTERS

Our healthcare operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with statutes and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows. There were no material capital expenditures for environmental matters in the year ended December 31, 2018.

ANTITRUST LAWS

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

Antitrust enforcement in the healthcare industry is currently a priority of the U.S. Federal Trade Commission ("FTC"). In recent years, the FTC has filed multiple administrative complaints and public comments challenging hospital transactions in several states. The FTC has focused its enforcement efforts on preventing hospital mergers that may, in the government's view, leave insufficient local options for patient services. In addition to hospital merger enforcement, the FTC has given increased attention to the effect of combinations involving other healthcare providers, including physician practices. The FTC has also entered into numerous consent decrees in the past several years settling allegations of price-fixing among providers.

REGULATIONS AFFECTING CONIFER'S OPERATIONS

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

BILLING AND COLLECTION ACTIVITIES

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

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

Conifer and its subsidiaries are also subject to both federal and state regulatory agencies who have the authority to investigate consumer complaints relating to a variety of consumer protection laws, including but not limited to the Telephone Consumer Protection Act and its state equivalent. These agencies may initiate enforcement actions, including actions to seek

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

PAYMENT ACTIVITY RISKS

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

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 *Standards 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 of quality, integrity, service, innovation and transparency.

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

Standards of Conduct— All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Standards of Conduct* to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and all of our contractors having functional

roles similar to our employees are also required to abide by our *Standards of Conduct* . The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable statutes and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

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

Non-Prosecution Agreement— In September 2016, our THSMI subsidiary entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia. The NPA requires, among other things, that we and THSMI (1) fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, (2) retain an independent compliance monitor to assess, oversee and monitor our compliance with the obligations under the NPA, (3) promptly report any evidence or allegations of actual or potential violations of the Anti-kickback Statute, (4) maintain our compliance and ethics program throughout our operations, including those of our subsidiaries, affiliates, agents and joint ventures (to the extent that we manage or control or THSMI manages or controls such joint ventures), and (5) notify the DOJ and undertake certain other obligations specified in the NPA relative to, among other things, any sale, merger or transfer of all or substantially all of our and THSMI's respective business operations or the business operations of our or its subsidiaries or affiliates, including an obligation to include in any contract for sale, merger, transfer or other change in corporate form a provision binding the purchaser to retain the commitment of us or THSMI, or any successor-in-interest thereto, to comply with the NPA obligations except as may otherwise be agreed by the parties to the NPA in connection with a particular transaction. Except as may otherwise be agreed by the parties in connection with a particular transaction, if, during the term of the NPA, THSMI undertakes or we undertake any change in corporate form that involves business operations that are material to our consolidated operations or to the operations of any subsidiaries or affiliates involved in the conduct described in the NPA, whether such transaction is structured as a sale, asset sale, merger, transfer or other change in corporate form, we are required to provide notice to the Offices at least 30 days prior to undertaking any such change in corporate form.

The NPA was originally scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained); however, the DOJ subsequently extended the expiration date of the NPA by nine months to November 1, 2020 following its determination that we had breached certain reporting obligations under the terms of the NPA. In the event the Offices determine, in their sole discretion, that the Company, or any of its subsidiaries or affiliates, has knowingly violated any provision of the NPA, the NPA could be further extended by the Offices, in their sole discretion without prejudice to the Offices' other rights under the NPA. Conversely, in the event the Offices find, in their sole discretion, that there exists a change in circumstances sufficient to eliminate the need for a monitor, or that the other provisions of the NPA have been satisfied, the oversight of the Monitor or the NPA itself may be terminated early.

If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal healthcare programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. The NPA provides that, in the event the DOJ determines that the Company or THSMI has breached the NPA, the DOJ will provide written notice prior to instituting any prosecution of the Company or THSMI resulting from such breach. Following receipt of such notice, the Company and THSMI have the opportunity to respond to the DOJ to explain the nature and circumstances of the breach, as well as the actions taken to address and remediate the situation, which the DOJ shall consider in determining whether to pursue prosecution of the Company, THSMI or its affiliates. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Availability of Documents— The full text of our *Quality, Compliance and Ethics Program Charter,* our *Standards of Conduct* , and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the "Our Commitment To Compliance" caption in the "About Us" section. A copy of our

Standards of Conduct is also available upon written request to our corporate secretary. Information about how to contact our corporate secretary is set forth under "Company Information" below. Amendments to the *Standards of Conduct* and any grant of a waiver from a provision of the *Standards of Conduct* requiring disclosure under applicable SEC rules will be disclosed at the same location as the *Standards of Conduct* on our website. A copy of the NPA is attached as an exhibit to our Current Report on Form 8-K filed with the SEC on October 3, 2016, and the letter agreement amending the term of the NPA, which was finalized on June 1, 2018, is attached as an exhibit to our Report on Form 10-Q for the quarter ended June 30, 2018.

INSURANCE

Property Insurance— We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy periods April 1, 2017 through March 31, 2018 and April 1, 2018 through March 31, 2019, 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, floods and named windstorms, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Floods and certain other covered losses, including fires and other perils, have a minimum deductible of $1 million.

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

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

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

COMPANY INFORMATION

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

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

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

EXECUTIVE OFFICERS

Information about our executive officers, as of February 25, 2019, is as follows:

Name	Position	Age
Ronald A. Rittenmeyer	Executive Chairman and Chief Executive Officer	71
Saumya Sutaria, M.D.	Chief Operating Officer	46
Daniel J. Cancelmi	Chief Financial Officer	56
Keith B. Pitts	Vice Chairman	61
Audrey T. Andrews	Senior Vice President and General Counsel	52

Mr. Rittenmeyer was named Tenet's executive chairman in August 2017 and chief executive officer in October 2017. He has served on Tenet's board of directors since 2010, most recently as lead director. He previously served as chairman of the board and chief executive officer of Millennium Health, a health solutions company. He served as the chairman, president and chief executive officer of Expert Global Solutions, Inc., a provider of business process outsourcing services, from 2011 to 2014. From 2005 to 2008, Mr. Rittenmeyer held a number of senior management positions with Electronic Data Systems Corporation, including chairman and chief executive officer from 2007 to 2008, president from 2006 to 2008, chief operating officer from 2005 to 2007 and executive vice president, global service delivery, from 2005 to 2006. Prior to that, he was a managing director of the Cypress Group, a private equity firm, serving from 2004 to 2005. He served as chairman, chief executive officer and president of Safety-Kleen Corp. from 2001 to 2004. Among his other leadership roles, Mr. Rittenmeyer served as chief executive officer and president of AmeriServe Food Distribution Inc. from 2000 to 2001, chairman, chief executive officer and president of RailTex, Inc. from 1998 to 2000, president and chief operating officer of Ryder TRS, Inc. from 1997 to 1998, president and chief operating officer of Merisel, Inc. from 1995 to 1996 and chief operating officer of Burlington Northern Railroad Co. from 1994 to 1995. Mr. Rittenmeyer received his bachelor of science degree in commerce and economics from Wilkes University and his M.B.A. from Rockhurst University. He is chairman of the Federation of American Hospitals' board of directors, and he currently serves on the board of directors of two other public companies: American International Group, Inc. and IQVIA Holdings Inc.

Dr. Sutaria was appointed Tenet's chief operating officer in January 2019. In this role, he oversees all of Tenet's acute care hospitals and hospital-affiliated outpatient facilities and physician practices. He also leads other functions across the enterprise within Tenet, USPI and Conifer. Prior to joining the Company, Dr. Sutaria worked for McKinsey & Company for 18 years, most recently as a Senior Partner providing advisory support for hospitals, healthcare systems, physicians groups, ambulatory care models, integrated delivery, and government-led delivery, while also working with institutional investors in healthcare. He previously held an associate clinical faculty appointment at the University of California at San Francisco, where he also engaged in postgraduate training with a focus in internal medicine and cardiology. Dr. Sutaria received his bachelor's degree in molecular and cellular biology and his bachelor's degree in economics, both from the University of California, Berkeley, as well as his M.D. from the University of California, San Diego.

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

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

Ms. Andrews was appointed senior vice president and general counsel in January 2013. In this capacity, she oversees the law department and government relations for Tenet, USPI and Conifer. From July 2008 through December 2012, she served as senior vice president and chief compliance officer and, prior to that, served as vice president and chief compliance officer from November 2006. She joined Tenet in 1998 as hospital operations counsel. Ms. Andrews received her J.D. and her bachelor's degree in government, both from the University of Texas at Austin. She is a member of the American and Texas Bar Associations and the American Health Lawyers Association.

FORWARD-LOOKING STATEMENTS

This report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements, including (but not limited to) disclosure regarding our future earnings, financial position, operational and strategic initiatives, and 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:

- Our ability to achieve operating and financial targets, attain expected levels of patient volumes, and identify and execute on measures designed to save or control costs or streamline operations, including our ability to realize savings under our cost-reduction initiatives;
- The outcome of the process we have undertaken to explore a sale of or other strategic alternatives for Conifer;
- Potential disruptions to our business or diverted management attention as a result of the Conifer strategic review process or our cost-reduction efforts, including our plans to outsource certain functions unrelated to direct patient care;
- The impact on our business of recent and future modifications of or judicial challenges to the Affordable Care Act and the enactment of, or changes in, other statutes and regulations affecting the healthcare industry generally;
- Cuts to Medicare and Medicaid payment rates or changes in reimbursement practices or to Medicaid supplemental payment programs;
- Adverse regulatory developments, government investigations or litigation;
- Adverse developments with respect to our ability to comply with the terms of the Non-Prosecution Agreement, including any breach of the agreement;
- Our ability to enter into or renew managed care provider arrangements on acceptable terms; and changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under managed care agreements;
- The effect that adverse economic conditions, consumer behavior and other factors have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things; and increases in the amount of uninsured accounts and deductibles and copays for insured accounts;
- Our success in completing acquisitions, divestitures and other corporate development transactions; and our success in entering into, and managing the relationships and risks associated with, joint ventures;
- Our success in recruiting and retaining physicians and other healthcare professionals;
- The impact of competition on all aspects of our business;

- 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;

- Potential security threats, catastrophic events and other disruptions affecting our information technology and related systems;

- 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; 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 statement.

ITEM 1A. RISK FACTORS

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

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

The initial expansion of health insurance coverage under the Affordable Care Act resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as 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 President issued an executive order in January 2017 declaring that it is the official policy of his administration to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations. In October 2017, the administration announced that reimbursements to insurance companies for ACA cost-sharing reduction plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, many insurers increased premiums for plans offered on ACA exchanges and a few withdrew entirely from offering plans on some of the exchanges. In addition, in December 2017, Congress passed and the President signed a tax reform bill into law that, among other things, eliminates the ACA's individual mandate penalty for not buying health insurance starting in 2019. The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that eliminating the mandate penalty starting in 2019 – and making no other changes to the then-current law – would cause the number of people with health insurance to decrease by 4 million in 2019 and 13 million in 2027. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. We cannot predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

Furthermore, there have also been successful judicial challenges to the ACA, including a December 2018 ruling by the U.S. District Court for the Northern District of Texas that the ACA's individual mandate is unconstitutional. Because the judge's order was stayed pending appeal, the decision's near-term impact on health insurance coverage under the ACA may be limited; however, uncertainty over the future of the ACA has intensified. The ultimate outcome of this decision and other

judicial challenges is indeterminate. We are also unable to predict the impact of administrative, regulatory and legislative changes, and market reactions to those changes, on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in Medicare reimbursement and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions scheduled to take effect in federal fiscal years 2020 through 2025) are made.

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

For the year ended December 31, 2018, approximately 20% and 9% of our net patient service revenues from our hospitals and related outpatient facilities were from the Medicare program and various state Medicaid programs, respectively, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows.

Several states in which we operate face budgetary challenges that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted provider fee programs or have received federal government waivers allowing them to test new approaches and demonstration projects to improve care. The timing of federal approval of these state-based Medicaid provider fee revenue programs – particularly the California provider fee program – may have an impact on our net operating revenues and cash flows in any given period. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays, changes to Medicaid supplemental payment programs or additional taxes on hospitals.

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

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

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

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

affecting healthcare providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

As we explore outsourcing and offshoring of certain functions unrelated to direct patient care to enhance efficiency, we must ensure that those operations will be compliant with U.S. healthcare industry-specific requirements. In addition, we are required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

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.

If we breach or otherwise fail to comply with our Non-Prosecution Agreement, we could be subject to criminal prosecution, substantial penalties and exclusion from participation in federal healthcare programs, any of which could adversely impact our business, financial condition, results of operations or cash flows.

In September 2016, one of our subsidiaries, Tenet HealthSystem Medical, Inc., entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia, as described in "Compliance and Ethics – Non-Prosecution Agreement" above. If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal healthcare programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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

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

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

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 year ended December 31, 2018 was approximately $9.2 billion , which represented approximately 65% of our total net patient service revenues. In addition, in the year ended December 31, 2018, our commercial managed care net inpatient revenue per admission from the hospitals and related outpatient facilities in our Hospital Operations and other segment was approximately 89% 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 ten managed care payers generated 65% of our managed care net patient service revenues for the year ended December 31, 2018. 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, 2018, 61% of our net accounts receivable for our Hospital Operations and other 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 charges in response to increasing costs. Furthermore, the ongoing trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on competitive terms. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services or any significant difficulties in collecting receivables from managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows.

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

Our future financial performance and level of profitability is dependent, in part, on various cost-reduction initiatives, including a recently announced strategy to explore outsourcing certain functions unrelated to direct patient care. We may encounter challenges in executing our cost-reduction initiatives and not achieve the intended cost savings. In addition, we may face wrongful termination, discrimination or other legal claims from employees affected by any workforce reductions, and we may incur substantial costs defending against such claims, regardless of their merits. Such claims may also significantly increase our severance costs. Workforce reductions, whether as a result of internal restructuring or in connection with outsourcing efforts, may result in the loss of numerous long-term employees, the loss of institutional knowledge and expertise, the reallocation of certain job responsibilities and the disruption of business continuity, all of which could negatively affect operational efficiencies and increase our operating expenses in the short term. Moreover, outsourcing and offshoring may expose us to additional risks, such as reduced control over operational quality and timing, foreign political and economic instability, and compliance and regulatory challenges. Our failure to effectively execute our cost-reduction initiatives may lead to significant volatility, and a decline, in the price of our common stock. We cannot guarantee that our cost-reduction initiatives will be successful, and we may need to take additional steps in the future to achieve our profitability goals.

We cannot provide any assurances that we will be successful in divesting assets in non-core markets or that we will complete the process we have initiated for the potential divestiture of or other transaction involving Conifer.

We continue to exit service lines, businesses and markets that we believe are no longer strategic to our long-term growth. To that end, in 2018 we divested eight hospitals in the United States, as well as all of our operations in the United Kingdom. In addition, in January 2019, we completed the previously announced sale of three hospitals in the Chicago area that we owned at December 31, 2018. We cannot provide any assurances that completed, planned or future divestitures will achieve their business goals or the cost and service synergies we expect. We also cannot predict the outcome of the process we have been exploring regarding strategic alternatives for Conifer, including a potential sale or merger, a tax-efficient spin-off or a combination of alternative transactions.

With respect to all proposed divestitures of assets or businesses, we may fail to obtain applicable regulatory approvals for such divestitures, including any approval that may be required under our NPA. 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 below) or agree to contractual restrictions that limit our ability to reenter the applicable market, which may be material. Furthermore, our divestiture or other corporate development activities 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 divestiture, and (3) the challenges associated with separating personnel and financial and other systems.

A divestiture or other separation of Conifer could adversely affect our earnings and cash flows.

Conifer contributes a significant portion of the Company's earnings and cash flows. We have been engaged in a process to consider a divestiture or other strategic alternatives for Conifer, such as a merger, a tax-efficient spin-off or a combination of alternative transactions. Although there can be no assurance that this process will result in a consummated transaction, any separation of all or a portion of Conifer's business could adversely affect our earnings and cash flows.

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

We believe broad economic factors (including high unemployment rates in some of the markets our facilities serve), instability in consumer spending, uncertainty regarding the future of the Affordable Care Act, and the continued shift of additional financial responsibility to insured patients through higher co-pays, deductibles and premium contributions, among other dynamics, have affected our service mix, revenue mix and volumes, as well as our ability to collect outstanding receivables. Any increase in the amount or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations. The U.S. economy remains unpredictable. If industry trends, such as reductions in commercial managed care enrollment and patient decisions to postpone or cancel elective and non-emergency healthcare procedures, worsen or if general economic conditions deteriorate, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

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

As a result of factors that have negatively affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. During the years ended December 31, 2018 and 2017, we recorded impairment charges of $77 million and $402 million , respectively. Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospitals' most recent projections. If these projections are not met, or negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material. Future restructuring of our operating structure that changes our goodwill reporting units could also result in future impairments of our goodwill. Any such charges could negatively impact our results of operations.

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 healthcare systems. 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 acquired may not be profitable or may not achieve the profitability that justifies the investments made. In addition, we may face significant challenges in integrating personnel and financial and other systems. Future acquisitions could result in potentially dilutive issuances of equity securities, the incurrence of additional debt and contingent liabilities, and increased operating expenses, any of which could adversely affect our results of operations and financial condition.

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

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

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

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

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

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 healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our results could be adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our results could be adversely affected. In addition, our relationships with not-for-profit healthcare systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current revenue rulings published by the 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 healthcare 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 healthcare 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 stockholders.

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

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

- 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.

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

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

We expect to encounter increased competition from health insurers and private equity companies seeking to acquire providers in the markets where we operate physician practices and, where permitted by law, employ physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Furthermore, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. All arrangements with physicians must also be fair market value

and commercially reasonable. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may choose not to refer patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

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

The operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, including nurses, therapists, pharmacists and lab technicians, as well as our employed physicians. We compete with other healthcare providers in recruiting and retaining employees, and, like others in the healthcare industry, we continue to experience a shortage of critical-care nurses in certain disciplines and geographic areas. As a result, from time to time, we may be required to enhance wages and benefits to recruit and retain experienced employees, make greater investments in education and training for newly licensed medical support personnel, or hire more expensive temporary or contract employees. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit 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 could adversely affect our labor costs. At December 31, 2018, approximately 26% of the employees in our Hospital Operations and other segment were represented by labor unions. Less than 1% of the employees in our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 35 of our hospitals, the majority of which are in California, Florida and Michigan. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is a possibility that strikes could occur, and our continued operation during any strikes could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods, which could result in increases in salaries, wages and benefits expense.

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

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

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

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

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

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, 2018, we had approximately $14.8 billion of total long-term debt, as well as $95 million in standby letters of credit outstanding in the aggregate, under our senior secured revolving credit facility (as amended, "Credit Agreement") and our letter of credit facility agreement (as amended, "LC Facility"). Our Credit Agreement is collateralized by patient accounts receivable of substantially all of our domestic wholly owned acute care and specialty hospitals, and our LC Facility is guaranteed and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. From time to time, we expect to engage in additional capital market, bank credit and other financing activities, depending on our needs and financing alternatives available at that time.

The interest expense associated with our indebtedness offsets a substantial portion of our operating income. During 2018, our interest expense was $1.004 billion and represented 61% of our $1.647 billion of operating income. As a result, relatively small percentage changes in our operating income can result in a relatively large percentage change in our net income and earnings per share, both positively and negatively. In addition:

- Our substantial indebtedness may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt.
- We may be more vulnerable in the event of a deterioration in our business, in the healthcare industry or in the economy generally, or if federal or state governments substantially limit or reduce reimbursement under the Medicare or Medicaid programs.
- Our debt service obligations reduce the amount of funds available for our operations, capital expenditures and corporate development activities, and may make it more difficult for us to satisfy our financial obligations.
- Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.
- Our significant indebtedness may result in the market value of our stock being more volatile, potentially resulting in larger investment gains or losses for our shareholders, than the market value of the common stock of other companies that have a relatively smaller amount of indebtedness.
- A significant portion of our outstanding debt is either subject to early prepayment penalties, such as "make-whole premiums," or is not currently callable. As a result, it may be costly to pursue debt repayment as a deleveraging strategy.

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

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

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

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

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

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

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

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

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

In addition, so long as any obligation or commitment is outstanding under our Credit Agreement and LC Facility, the terms of such facilities require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. Our ability to meet these restrictive covenants and financial ratio may be affected by events beyond our

control, and we cannot assure you that we will meet those tests. These restrictions could limit our ability to obtain future financing, make acquisitions or needed capital expenditures, withstand economic downturns in our business or the economy in general, conduct operations or otherwise take advantage of business opportunities that may arise. In addition, a breach of any of these covenants could cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

Despite current indebtedness levels, we may be able to incur substantially more debt 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 continue to sell assets, including the potential divestiture of or other strategic alternative involving Conifer, 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 billion, with a $300 million subfacility for standby letters of credit. Based on our eligible receivables, $998 million was available for borrowing under the Credit Agreement at December 31, 2018. Our LC Facility provides for the issuance of standby and documentary letters of credit in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). At December 31, 2018, we had no cash borrowings outstanding under the Credit Agreement, and we had $95 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.

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

Information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive and confidential data, including protected health information, personally identifiable information, and our proprietary and confidential business performance data. We utilize electronic health records and other information technology in connection with all of our operations, including our billing and supply chain and labor management operations. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the integrity, security and availability of the data we process, transmit and store, the information technology and infrastructure we use have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. Attacks or breaches could impact the integrity, security or availability of data we process, transmit or store, or they could disrupt our information technology systems, devices or businesses. While we are not aware of having experienced a material breach of our systems, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we will be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, and invest in new technology designed to mitigate security risks. Furthermore, we have an increased risk of security breaches or compromised intellectual property rights as a result of outsourcing certain functions unrelated to direct patient care. Though we have insurance against some cyber-risks and attacks, it may not offset the impact of a material loss event.

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

Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, hurricane, telecommunications failure, ransomware attack, terrorist attack or other catastrophic event. Any breach or system interruption of our information systems or of third parties with access to our sensitive and confidential data could result in: the unauthorized disclosure, misuse or loss of such data; interruptions and delays in our normal business operations (including the collection of revenues); patient harm; potential liability under privacy, security, consumer protection or other applicable laws;

regulatory penalties; and negative publicity and damage to our reputation. Any of these could have a material adverse effect on our business, financial position, results of operations or cash flows.

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, 2018, we had federal net operating loss ("NOL") carryforwards of approximately $1.0 billion pre-tax available to offset future taxable income. These NOL carryforwards will expire in the years 2027 to 2034 . Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income that may be offset by the NOL carryforwards if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an 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.

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

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

The ACA also created the CMS Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria. In 2015, CMS finalized a five-year bundled payment model, called the Comprehensive Care for Joint Replacement ("CJR") model, which includes hip and knee replacements, as well as other major leg procedures. Seventeen hospitals in our Hospital Operations and other segment and four of USPI's surgical hospitals currently participate in the CJR model. In addition, 42 hospitals in our Hospital Operations and other segment and five of USPI's surgical hospitals participate in the CMS Bundled Payments for Care Improvement Advanced ("BPCIA") program that became effective October 1, 2018. USPI also holds the CMS contract for four physician group practices participating in the BPCIA program. We cannot predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

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

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

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

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

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 16 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 15, 2019, there were 3,839 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.

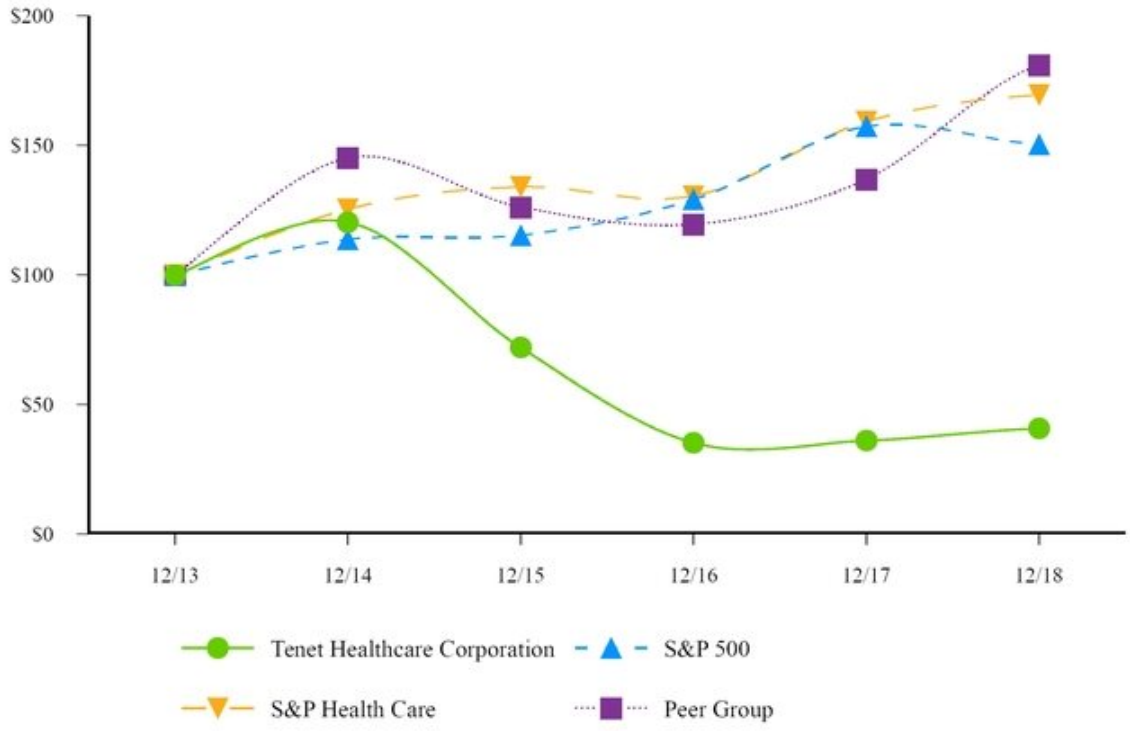
Equity Compensation. Refer to Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of Part III of this report, as well as Note 9 to our Consolidated Financial Statements, for information regarding securities authorized for issuance under our equity compensation plans.

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

- Standard & Poor's 500 Stock Index (a broad equity market index in which we are not included);
- Standard & Poor's Health Care Composite Index (a published industry index in which we are not included); and
- A group made up of us and our hospital company peers (namely, Community Health Systems, Inc. (CYH), HCA Healthcare, Inc. (HCA), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS)), which we refer to as our "Peer Group". LifePoint Health, Inc. (LPNT), which was a member of our Peer Group index in prior years, is not included because it ceased having publicly traded equity securities in November 2018.

Performance data assumes that $100.00 was invested on December 31, 2013 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.

COMPARISON OF FIVE-YEAR CUMULATIVE TOTAL RETURN



	12/13	12/14	12/15	12/16	12/17	12/18
Tenet Healthcare Corporation	$ 100.00	$ 120.30	$ 71.94	$ 35.23	$ 35.99	$ 40.69
S&P 500	$ 100.00	$ 113.69	$ 115.26	$ 129.05	$ 157.22	$ 150.33
S&P Health Care	$ 100.00	$ 125.34	$ 133.97	$ 130.37	$ 159.15	$ 169.44
Peer Group	$ 100.00	$ 145.00	$ 126.07	$ 119.47	$ 136.82	$ 180.80

ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2014 through 2018. Effective January 1, 2018, we adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09") using a modified retrospective method of application to all contracts existing on January 1, 2018. For our Hospital and other and Ambulatory Care segments, the adoption of ASU 2014-09 resulted in changes to our presentation of revenue primarily related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding material reduction in the amounts presented separately as provision for doubtful accounts. Effective June 16, 2015, we completed a transaction that combined our freestanding ambulatory surgery and imaging center assets with the surgical facility assets of United Surgical Partners International, Inc. into a new joint venture called USPI Holding Company, Inc. ("USPI"). At December 31, 2018 , we owned 95.0% of USPI. The tables below include USPI for the post-acquisition period only. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2018	2017	2016	2015	2014
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts		$ 20,613	$ 21,070	$ 20,111	$ 17,908
Less: Provision for doubtful accounts		1,434	1,449	1,477	1,305
Net operating revenues	**$ 18,313**	**19,179**	**19,621**	**18,634**	**16,603**
Equity in earnings of unconsolidated affiliates	**150**	**144**	**131**	**99**	**12**
Operating expenses:					
Salaries, wages and benefits	8,634	9,274	9,328	8,990	8,013
Supplies	3,004	3,085	3,124	2,963	2,630
Other operating expenses, net	4,259	4,570	4,891	4,555	4,114
Electronic health record incentives	(3)	(9)	(32)	(72)	(104)
Depreciation and amortization	802	870	850	797	849
Impairment and restructuring charges, and acquisition-related costs	209	541	202	318	153
Litigation and investigation costs	38	23	293	291	25
Net gains on sales, consolidation and deconsolidation of facilities	(127)	(144)	(151)	(186)	—
Operating income	**1,647**	**1,113**	**1,247**	**1,077**	**935**
Interest expense	(1,004)	(1,028)	(979)	(912)	(754)
Other non-operating expense, net	(5)	(22)	(20)	(20)	(10)
Gain (loss) from early extinguishment of debt	1	(164)	—	(1)	(24)
Income (loss) from continuing operations, before income taxes	**639**	**(101)**	**248**	**144**	**147**
Income tax expense	(176)	(219)	(67)	(68)	(49)
Income (loss) from continuing operations, before discontinued operations	**463**	**(320)**	**181**	**76**	**98**
Less: Net income available to noncontrolling interests from continuing operations	355	384	368	218	64
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders from continuing operations	**$ 108**	**$ (704)**	**$ (187)**	**$ (142)**	**$ 34**
Basic earnings available (loss attributable) per share to Tenet Healthcare Corporation common shareholders from continuing operations	**$ 1.06**	**$ (7.00)**	**$ (1.88)**	**$ (1.43)**	**$ 0.35**
Diluted earnings available (loss attributable) per share to Tenet Healthcare Corporation common shareholders from continuing operations	**$ 1.04**	**$ (7.00)**	**$ (1.88)**	**$ (1.43)**	**$ 0.34**

The operating results data presented above is not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services ("CMS") of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated implicit price concessions; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; gains (losses) on sales, consolidation and deconsolidation of facilities; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains (losses) from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: changes in federal and state healthcare regulations; the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; hospital performance data on quality measures and patient satisfaction, as well as standard charges for services; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and the timing of elective procedures.

BALANCE SHEET DATA

	December 31,				
	2018	2017	2016	2015	2014
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 779	$ 1,241	$ 1,223	$ 863	$ 393
Total assets	22,409	23,385	24,701	23,682	17,951
Long-term debt, net of current portion	14,644	14,791	15,064	14,383	11,505
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,420	1,866	2,393	2,266	401
Noncontrolling interests	806	686	665	267	134
Total equity	687	539	1,082	958	785

CASH FLOW DATA

	Years Ended December 31,				
	2018	2017	2016	2015	2014
	(In Millions)				
Net cash provided by operating activities	$ 1,049	$ 1,200	$ 558	$ 1,026	$ 687
Net cash provided by (used in) investing activities	(115)	21	(430)	(1,317)	(1,322)
Net cash provided by (used in) financing activities	(1,134)	(1,326)	232	454	715

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our Hospital Operations and other segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 5 to the accompanying Consolidated Financial Statements , certain of our facilities were classified as held for sale at December 31, 2018 . Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI"), in which we own a 95% interest, and included nine European Surgical Partners Limited ("Aspen") facilities until their divestiture effective August 17, 2018. At December 31, 2018 , USPI had interests in 255 ambulatory surgery centers, 36 urgent care centers, 23 imaging centers and 23 surgical hospitals in 27 states. Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities , through our Conifer Holdings, Inc. ("Conifer") subsidiary. Nearly all of the services comprising the operations of our Conifer segment are provided directly by Conifer Health Solutions, LLC, in which we owned 76.2% as of December 31, 2018, or by one of its direct or indirect wholly owned subsidiaries. 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 and Other Segment
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Recently Issued Accounting Standards
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per admission, per adjusted patient admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 68 hospitals operated throughout the years ended December 31, 2018 and 2017 , (ii) three Houston-area hospitals, which we divested effective August 1, 2017 , (iii) Abrazo Maryvale Campus, which we closed in December 2017 , (iv) two Philadelphia-area hospitals, which we divested effective January 11, 2018 , (v) MacNeal Hospital, which we divested effective March 1, 2018 and (vi) Des Peres Hospital, which we divested effective May 1, 2018 . The results of our Aspen facilities are included until August 17, 2018, the date of divestiture. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. In addition, although we operated four North Texas hospitals throughout the year ended December 31, 2017 and from January 1 through February 28, 2018 as part of a joint venture , we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Sale of Three Hospitals and Related Operations in Chicago Area— Effective January 28, 2019, we completed the sale of three hospitals and hospital-affiliated operations in the Chicago area. As a result of this transaction, we received net pre-tax cash proceeds of $42 million.

Debt Refinancing Transactions— On February 5, 2019, we sold $1.5 billion aggregate principal amount of 6.250% senior secured second lien notes, which will mature on February 1, 2027 (the "2027 Senior Secured Second Lien Notes"). We will pay interest on the 2027 Senior Secured Second Lien Notes semi-annually in arrears on February 1 and August 1 of each year, which payments will commence on August 1, 2019. The proceeds from the sale of the 2027 Senior Secured Second Lien Notes were used, after payment of fees and expenses, together with cash on hand and borrowings under our senior secured revolving credit facility, to fund the redemption of all $300 million aggregate principal amount of our outstanding 6.750% senior notes due 2020 and all $750 million aggregate principal amount of our outstanding 7.500% senior

secured second lien notes due 2022, and will be used to fund the repayment upon maturity of all $468 million aggregate principal amount of our outstanding 5.500% senior unsecured notes due March 1, 2019. In connection with the redemptions, we expect to record a loss from early extinguishment of debt of approximately $47 million in the three months ending March 31, 2019 , primarily related to the difference between the redemption prices and the par values of the notes, as well as the write-off of the associated unamortized issuance costs.

TRENDS AND STRATEGIES

The healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA"). It is difficult to predict the full impact of regulatory uncertainty on our future revenues and operations. In addition, we believe that several key trends are shaping 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 industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (4) consolidation continues across the entire healthcare sector.

Driving Growth in Our Hospital Systems— We are committed to better positioning our hospital systems and competing more effectively in the ever-evolving healthcare environment. We are focused on improving operational effectiveness, increasing capital efficiency and margins, enhancing patient satisfaction, growing our higher-acuity inpatient service lines, expanding patient access points, and exiting service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. We have undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions (including streamlining corporate overhead and centralized support functions), the renegotiation of contracts with suppliers and vendors, and the consolidation of office locations. We achieved our targeted savings in 2018, but are continuing to look for additional areas for savings. Most of the savings in 2018 were achieved through actions within both our Hospital Operations and other segment and our Conifer segment. In conjunction with these initiatives, we incurred restructuring charges related to employee severance payments of $68 million in the year ended December 31, 2018 , and we expect to incur additional such restructuring charges in 2019.

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 chronic disease patients; (3) offering greater affordability and predictability, including simplified admissions and discharge procedures, particularly in our outpatient centers; (4) improving our culture of service; and (5) creating health and benefit programs, patient education and health literacy materials that are customized to the needs of the communities we serve. Through these efforts, we intend to improve the customer care experience in every part of our operations.

Expansion of Our Ambulatory Care Segment— We remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We believe USPI's surgery centers 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. In addition, we have continued to grow our imaging and urgent care businesses through USPI to reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

Exploration of Strategic Alternatives for Conifer While Continuing to Drive Conifer's Growth— We previously announced a number of actions to support our goals of improving financial performance and enhancing shareholder value, including the exploration of a potential sale of Conifer. In addition to a potential sale, we are considering other strategic alternatives for Conifer, such as a merger, a tax efficient spin-off or a combination of alternative transactions. There can be no assurance that this process will result in any transaction.

Conifer serves approximately 750 Tenet and non-Tenet hospital and other clients nationwide. In addition to providing revenue cycle management services to healthcare 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.

Improving Profitability— We are focused 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 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 are experiencing higher growth rates than traditional Medicare plans, and contracting strategies that create shared value with payers should help us grow our patient volumes over time. In 2019, we are continuing to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing certain functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

Reducing Our Leverage— All of our outstanding long-term debt has a fixed rate of interest, and the maturity dates of our notes are staggered from 2020 through 2031. Although 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, it is nonetheless our long-term objective to lower our ratio of debt-to-Adjusted EBITDA, primarily through more efficient capital allocation and Adjusted EBITDA growth, which should lower our refinancing risk and increase the potential for us to continue to use lower rate secured debt to refinance portions of our higher rate unsecured debt.

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

RECENT RESULTS OF OPERATIONS

We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2018 and 2017 on a continuing operations basis, which includes the results of (i) our same 68 hospitals operated throughout the three months ended December 31, 2018 and 2017 , (ii) three Houston-area hospitals, which we divested effective August 1, 2017 , (iii) our Abrazo Maryvale Campus, which we closed in December 2017 , (iv) two Philadelphia-area hospitals, which we divested effective January 11, 2018 , (v) MacNeal Hospital, which we divested effective March 1, 2018 , and (vi) Des Peres Hospital, which we divested effective May 1, 2018 . Although we operated four North Texas hospitals throughout the year ended December 31, 2017 and from January 1 through February 28, 2018 as part of a joint venture , we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016. The following tables also show information about facilities in our Ambulatory Care segment that we control and, therefore, consolidate. The results of our Aspen facilities are included until August 17, 2018, the date of divestiture.

Selected Operating Statistics	Continuing Operations Three Months Ended December 31, 2018	2017	Increase (Decrease)	
Hospital Operations and other – hospitals and related outpatient facilities				
Number of hospitals (at end of period)	68	72	(4)	(1)
Total admissions	170,407	186,185	(8.5)%	
Adjusted patient admissions (2)	308,113	332,642	(7.4)%	
Paying admissions (excludes charity and uninsured)	160,172	176,158	(9.1)%	
Charity and uninsured admissions	10,235	10,027	2.1 %	
Emergency department visits	649,544	711,268	(8.7)%	
Total surgeries	108,535	118,896	(8.7)%	
Patient days — total	779,728	857,728	(9.1)%	
Adjusted patient days (2)	1,383,372	1,505,130	(8.1)%	
Average length of stay (days)	4.58	4.61	(0.7)%	
Average licensed beds	17,935	19,320	(7.2)%	
Utilization of licensed beds (3)	47.3%	48.3%	(1.0)%	(1)
Total visits	1,734,523	1,901,864	(8.8)%	
Paying visits (excludes charity and uninsured)	1,617,970	1,777,790	(9.0)%	
Charity and uninsured visits	116,553	124,074	(6.1)%	
Ambulatory Care				
Total consolidated facilities (at end of period)	227	227	—	(1)
Total cases	499,803	488,046	2.4 %	

(1) The change is the difference between the 2018 and 2017 amounts shown.

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

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

Total admissions decreased by 15,778 , or 8.5% , in the three months ended December 31, 2018 compared to the three months ended December 31, 2017 , and total surgeries decreased by 10,361 , or 8.7% , in the 2018 period compared to the 2017 period. Our emergency department visits decreased 8.7% in the three months ended December 31, 2018 compared to the same period in the prior year. Our volumes from continuing operations in the three months ended December 31, 2018 compared to the three months ended December 31, 2017 were negatively affected by the closure of our Abrazo Maryvale Campus in December 2017, the sale of our Philadelphia-area facilities effective January 11, 2018, the sale of MacNeal Hospital and affiliated operations effective March 1, 2018, and the sale of Des Peres Hospital and affiliated operations effective May 1, 2018. Our Ambulatory Care total cases increased 2.4% in the three months ended December 31, 2018 compared to the 2017 period.

Revenues	Continuing Operations Three Months Ended December 31, 2018	2017	Increase (Decrease)
Net operating revenues			
Hospital Operations and other prior to inter-segment eliminations	$ 3,843	$ 4,194	(8.4)%
Ambulatory Care	554	545	1.7 %
Conifer	372	394	(5.6)%
Inter-segment eliminations	(150)	(155)	(3.2)%
Total	$ 4,619	$ 4,978	(7.2)%

Net operating revenues decreased by $359 million , or 7.2% , in the three months ended December 31, 2018 compared to the same period in 2017 , primarily due to the sale and closure of facilities described above, as well as the decrease in net revenues from the California provider fee program. In the 2018 period, we recognized $64 million of net revenues from the California provider fee program compared to $267 million recognized in the 2017 period due to CMS' approval of the 2017 program in December of that year. For our Hospital Operations and other segment, the impact of lower volumes on net operating revenues was partially mitigated by improved managed care pricing.

Our accounts receivable days outstanding ("AR Days") from continuing operations were 56.8 days at December 31, 2018 and 55.8 days at December 31, 2017 , compared to our target of less than 55 days. This calculation includes our Hospital Operations and other contract assets subsequent to the adoption of ASU 2014-09 effective January 1, 2018 and the

accounts receivable of our Chicago-area facilities that have been classified in assets held for sale on our Consolidated Balance Sheet at December 31, 2018 , and excludes (i) three Houston-area hospitals, which we divested effective August 1, 2017 , (ii) Abrazo Maryvale Campus, which we closed in December 2017 , (iii) two Philadelphia-area hospitals, which we divested effective January 11, 2018 , (iv) MacNeal Hospital, which we divested effective March 1, 2018 , (v) Des Peres Hospital, which we divested effective May 1, 2018 , (vi) all nine Aspen facilities, which we divested effective August 17, 2018, (vii) health plan revenues, and (viii) our California provider fee revenues.

	Continuing Operations		
	Three Months Ended December 31,		
Selected Operating Expenses	2018	2017	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,785	$ 1,887	(5.4)%
Supplies	641	685	(6.4)%
Other operating expenses	921	930	(1.0)%
Total	$ 3,347	$ 3,502	(4.4)%
Ambulatory Care			
Salaries, wages and benefits	$ 160	$ 165	(3.0)%
Supplies	114	113	0.9 %
Other operating expenses	84	93	(9.7)%
Total	$ 358	$ 371	(3.5)%
Conifer			
Salaries, wages and benefits	$ 211	$ 232	(9.1)%
Supplies	1	2	(50.0)%
Other operating expenses	73	81	(9.9)%
Total	$ 285	$ 315	(9.5)%
Total			
Salaries, wages and benefits	$ 2,156	$ 2,284	(5.6)%
Supplies	756	800	(5.5)%
Other operating expenses	1,078	1,104	(2.4)%
Total	$ 3,990	$ 4,188	(4.7)%
Rent/lease expense (1)			
Hospital Operations and other	$ 58	$ 59	(1.7)%
Ambulatory Care	20	20	— %
Conifer	4	5	(20.0)%
Total	$ 82	$ 84	(2.4)%

(1) Included in other operating expenses.

	Continuing Operations		
	Three Months Ended December 31,		
Selected Operating Expenses per Adjusted Patient Admission	2018	2017	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits per adjusted patient admission (1)	$ 5,791	$ 5,662	2.3%
Supplies per adjusted patient admission (1)	2,079	2,058	1.0%
Other operating expenses per adjusted patient admission (1)	2,991	2,772	7.9%
Total per adjusted patient admission	$ 10,861	$ 10,492	3.5%

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

Salaries, wages and benefits per adjusted patient admission increased 2.3% in the three months ended December 31, 2018 compared to the same period in 2017 . This change is primarily due to the effect of lower volumes on operating leverage due to certain fixed staffing costs, annual merit increases for certain of our employees, increased accruals for annual incentive compensation and increased health benefits costs, partially offset by the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives in the three months ended December 31, 2018 compared to the three months ended December 31, 2017 .

Supplies expense per adjusted patient admission increased 1.0% in the three months ended December 31, 2018 compared to the three months ended December 31, 2017 . The change in supplies expense was primarily attributable to growth in our higher acuity supply-intensive surgical services, partially offset by the impact of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

Other operating expenses per adjusted patient admission increased by 7.9% in the three months ended December 31, 2018 compared to the prior-year period. This increase is primarily due to higher medical fees per adjusted patient admission, the effect of lower volumes on operating leverage due to certain fixed costs and increased malpractice expense for our Hospital Operations and other segment, which was $44 million higher in the 2018 period compared to the 2017 period. The 2018 period included an unfavorable adjustment of approximately $8 million from a 42 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $4 million from a 17 basis point increase in the interest rate in the 2017 period.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $411 million at December 31, 2018 compared to $500 million at September 30, 2018 .

Significant cash flow items in the three months ended December 31, 2018 included:

- Net cash provided by operating activities before interest, taxes, discontinued operations and restructuring charges, acquisition-related costs, and litigation costs and settlements of $626 million ;
- Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements of $50 million ;
- Capital expenditures of $213 million ;
- $16 million of payments for the purchases of businesses or joint venture interests;
- $84 million of payments for the purchase of equity investments;
- Proceeds from the sales of facilities and other assets of $45 million ;
- Proceeds from sale of marketable securities, long-term investments and other assets of $34 million ;
- Interest payments of $324 million ;
- $32 million of payments to purchase $32 million aggregate principal amount of our 5.500% senior unsecured notes due 2019; and
- $71 million of distributions paid to noncontrolling interests.

Net cash provided by operating activities was $1.049 billion in the year ended December 31, 2018 compared to $1.200 billion in the year ended December 31, 2017 . Key factors contributing to the change between the 2018 and 2017 periods include the following:

- An increase of $38 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;
- Decreased cash receipts of $31 million related to the California provider fee program;
- Additional interest payments of $37 million in the 2018 period primarily due to the six-month interest payment in January 2018 related to our 7.500% senior secured second lien notes due 2022, which were issued in December 2016, and changes in the timing of certain interest payments as a result of our refinancing transactions in 2017;
- Lower income tax payments of $31 million in the 2018 period;

- Increased cash flows from our health plan businesses of $101 million due to cash outflows in the 2017 period resulting from the sales and wind-down of these businesses in 2017, compared to negligible cash flows in the 2018 period; and

- The timing of other working capital items, including $129 million of additional payments for professional and general liability claims and expenses in the 2018 period.

SOURCES OF REVENUE FOR OUR HOSPITAL OPERATIONS AND OTHER 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 self-pay patients (that is, patients who do not have health insurance and are not covered by some other form of third-party arrangement).

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

	Years Ended December 31,		
Net Patient Service Revenues Less Implicit Price Concessions and Provision for Doubtful Accounts from:	**2018**	**2017**	**2016**
Medicare	20.5%	21.9%	22.4%
Medicaid	9.2%	8.8%	8.9%
Managed care (1)	65.4%	64.6%	64.3%
Self-pay	0.7%	0.6%	0.4%
Indemnity and other	4.2%	4.1%	4.0%

(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:	**2018**	**2017**	**2016**
Medicare	25.4%	26.0%	26.1%
Medicaid	6.3%	6.5%	7.0%
Managed care (1)	59.7%	59.6%	59.2%
Self-pay	6.0%	5.5%	5.4%
Indemnity and other	2.6%	2.4%	2.3%

(1) Includes Medicare and Medicaid managed care programs.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services, 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 58 million individuals rely on healthcare benefits through Medicare, and approximately 73 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 certain younger people with certain disabilities and conditions, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage. Unlike Medicaid, the CHIP is limited in duration and requires the enactment of reauthorizing legislation. During the three months ended March 31, 2018, separate pieces of legislation were enacted extending CHIP funding for a total of ten years from federal fiscal year ("FFY") 2018 (which began on October 1, 2017) through FFY 2027.

The Affordable Care Act

The expansion of Medicaid in the 36 states (including four in which we currently operate acute care hospitals) and the District of Columbia that have taken action to do so is financed through:

- negative adjustments to the annual market basket updates for the Medicare hospital inpatient and outpatient prospective payment systems, which began in 2010 and under current law expire on September 30, 2019, as well as additional negative "productivity adjustments" to the annual market basket updates, which began in 2011; and

- reductions to Medicare and Medicaid disproportionate share hospital ("DSH") payments, which began for Medicare payments in FFY 2014 and, under current law, are scheduled to commence for Medicaid payments on October 1, 2019.

In December 2017, Congress passed and the President signed a tax reform bill into law that, among other things, eliminates the ACA's individual mandate penalty for not buying health insurance starting in 2019. The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that eliminating the mandate penalty starting in 2019 – and making no other changes to the then-current law – would cause the number of people with health insurance to decrease by 4 million in 2019 and 13 million in 2027. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. We cannot predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law. Furthermore, there have also been successful judicial challenges to the ACA, including a December 2018 ruling by the U.S. District Court for the Northern District of Texas that the ACA's individual mandate is unconstitutional. Because the judge's order was stayed pending appeal, the decision's near-term impact on health insurance coverage under the ACA may be limited; however, uncertainty over the future of the ACA has intensified. The ultimate outcome of this decision and other judicial challenges is indeterminate. We are also unable to predict the impact of administrative, regulatory and legislative changes, and market reactions to those changes, on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in Medicare reimbursement and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions scheduled to take effect in FFYs 2020 through 2025, as described below) are made.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient service revenues from continuing operations of the hospitals and related outpatient facilities in our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2018 , 2017 and 2016 are set forth in the following table:

	Years Ended December 31,		
Revenue Descriptions	**2018**	**2017**	**2016**
Medicare severity-adjusted diagnosis-related group — operating	$ 1,526	$ 1,659	$ 1,705
Medicare severity-adjusted diagnosis-related group — capital	137	162	157
Outliers	83	89	77
Outpatient	748	762	787
Disproportionate share	228	265	293
Other (1)	160	306	367
Total Medicare net patient service revenues	**$ 2,882**	**$ 3,243**	**$ 3,386**

(1) The other revenue category includes Medicare Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") revenues, IME revenues earned by our children's hospitals (one of which we divested in 2018) under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS, inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital (which was divested in 2017), other revenue adjustments, and adjustments to the estimates for current and prior-year cost reports and related valuation allowances.

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

Acute Care Hospital Inpatient Prospective Payment System

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

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

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

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

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

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC DSH Amount"). The UC DSH Amount is a hospital's share of a pool of funds that the CMS Office of the Actuary estimates would equal 75% of Medicare DSH that otherwise would have been paid under the pre-ACA 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. Although the statute requires that each hospital's cost of uncompensated care as a percentage of the total uncompensated care cost of all DSH hospitals be used to allocate the pool, CMS previously determined that the available cost data from cost reports was unreliable and for FFYs 2014 through 2017 used low-income days (i.e., Medicaid days) to distribute UC DSH Amounts. Beginning in FFY 2018, CMS commenced a three-year transition to using uncompensated care cost data to distribute the UC DSH Amounts. As of December 31, 2018, 57 of our acute care hospitals in continuing operations, three of which were divested in January 2019, qualified for Medicare DSH payments.

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

Direct Graduate and Indirect Medical Education Payments —The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of DGME and IME payments. As of December 31, 2018, 24 of our hospitals in continuing operations, three of which were divested in January 2019, 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 ("HRRP") – Under the HRRP 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 ("HAC") Reduction Program ("HACRP") – Under the HACRP, overall inpatient payments are reduced by 1% for hospitals in the worst performing quartile of risk-adjusted quality measures for reasonable preventable HACs.

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, 2018, 23 of our general hospitals in continuing operations, two of which were divested in January 2019, 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, 2018, we operated one freestanding IRF, and 18 of our general hospitals in continuing operations, two of which were divested in January 2019, 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. The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") established a new set of updates for clinicians billing under the MPFS that set the conversion factor.

Cost Reports

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

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

Medicare Claims Reviews

HHS estimates that the overall FFY 2018 Medicare fee-for-service ("FFS") improper payment rate for the program is approximately 8.1%. The FFY 2018 error rate for Hospital IPPS payments is approximately 4.3%. CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. CMS has established several initiatives to prevent or identify improper payments before a claim is paid, and to identify and recover improper payments after paying a claim. The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types. Under the authority of the Act, CMS employs a variety of contractors (e.g., 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 will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted 19.8% , 20.4% and 20.3% of total net patient service revenues less implicit price concessions and provision for doubtful accounts of our acute care hospitals and related outpatient facilities for the years ended December 31, 2018 , 2017 and 2016 , respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the years ended December 31, 2018 , 2017 and 2016 , our total Medicaid revenues attributable to DSH and other supplemental revenues were $847 million , $864 million and $906 million , respectively. The $847 million of total Medicaid revenues attributable to DSH and other supplemental revenues for the year ended December 31, 2018 was comprised of $262 million related to the California provider fee program described below, $286 million related to the Michigan provider fee program, $136 million related to Medicaid DSH programs in multiple states, $120 million related to the Texas 1115 waiver program described below, and $43 million from a number of other state and local programs.

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

The California Department of Health Care Services implemented its first Hospital Quality Assurance Fee ("HQAF") program in 2010. The HQAF program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. CMS approved the fifth and most recent phase of the program ("HQAF V") covering the period January 2017 through June 2019 in the three months ended December 31, 2017. Our hospitals recognized HQAF revenues, net of provider fees and other expenses, of $262 million , $267 million and $232 million in calendar years 2018 , 2017 and 2016 , respectively. In November 2016, California voters approved a state constitutional amendment measure that extends indefinitely the statute that imposes fees on hospitals to obtain federal matching funds. Because HQAF funding levels are based in part on Medi-Cal utilization, changes in coverage of individuals under the Medi-Cal program could affect the net revenues and cash flows of our hospitals under HQAF V and subsequent phases of the HQAF program. Also, because funding of the HQAF program is dependent on federal funding, we cannot provide assurances that such funding will continue in future periods.

Certain of our Texas hospitals participate in the Texas 1115 waiver program. The previous waiver term expired on December 31, 2017, and the current waiver extension ("Waiver"), which was approved during the three months ended December 31, 2017, covers the period January 1, 2018 through September 30, 2022. The Waiver is funded by intergovernmental transfer payments from local government entities, and includes two funding pools – Uncompensated Care and Delivery System Reform Payment. In 2018 , we recognized $120 million of revenues from the Texas 1115 waiver program. Separately, during the same period, we incurred $78 million of expenses related to funding indigent care services by certain of our Texas hospitals. Under the terms of the Waiver, the amount of the funding pool for the period January 1, 2018 through September 30, 2019 is consistent with the latter years of the previous waiver; however, effective October 1, 2019, CMS requires that the funding pool be resized based on aggregate hospital charity cost. The final funding pool amount for the period October 1, 2019 through the end of the current Waiver term has not been determined. We are unable to predict the changes to the funding pool amount or the allocation of the funding pool amount, which could result in an increase or decrease to our net revenues and cash flows. Furthermore, we cannot provide any assurances as to future extensions of the Texas 1115 waiver program, or the ultimate amount of revenues that our hospitals may receive from this program following the expiration of the Waiver.

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

Medicaid and Managed Medicaid net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations and other segment from Medicaid-related programs in the states in which our facilities are (or were, as the case may be) located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2018 , 2017 and 2016 are set forth in the following table.

Hospital Location	Years Ended December 31, 2018	2017	2016
Alabama	$ 91	$ 88	$ 80
Arizona	165	177	199
California	875	862	818
Florida	231	232	261
Georgia	—	(3)	19
Illinois	89	143	106
Massachusetts	94	83	89
Michigan	749	710	663
Missouri	—	2	2
North Carolina	—	(1)	(2)
Pennsylvania	8	285	279
South Carolina	53	46	50
Tennessee	35	36	39
Texas	398	371	466
	$ 2,788	**$ 3,031**	**$ 3,069**

Medicaid and Managed Medicaid revenues comprised 46% and 54% , respectively, of our Medicaid-related net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations and other segment for the year ended December 31, 2018 .

Regulatory and Legislative Changes

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

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems. The updates generally become effective October 1, the beginning of the federal fiscal year. In August 2018, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2019 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.9% for MS-DRG operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record ("EHR") technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS also made certain adjustments to the 2.9% market basket increase that result in a net operating payment update of 1.85% (before budget neutrality adjustments), including:
    - Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.8%, respectively; and
    - A 0.5% increase required under the 21st Century Cures Act;
- Updates to the three factors used to determine the amount and distribution of UC DSH Amounts, including the continuation of the transition from using low-income days to estimated uncompensated care costs for the distribution of the UC DSH Amounts;
- A 1.27% net increase in the capital federal MS-DRG rate;

- A decrease in the cost outlier threshold from $26,537 to $25,769;
- The application of the Medicare IPPS post-acute transfer payment policy to "early discharges" from the hospital to hospice care as required by the Bipartisan Budget Act of 2018; and
- Effective January 1, 2019, the requirement that hospitals make available to the public a list of their current standard charges via the Internet in a machine-readable format and update this information at least annually or more often as appropriate.

According to CMS, the combined impact of the payment and policy changes in the Final IPPS Rule for operating costs will yield an average 2.4% increase in Medicare operating MS-DRG FFS payments for hospitals in large urban areas (populations over one million), and an average 2.1% increase in operating MS-DRG FFS payments for proprietary hospitals in FFY 2019. We estimate that all of the payment and policy changes affecting operating MS-DRG payments, including those affecting Medicare DSH amounts and the hospice transfer payment policy, will result in an estimated 1.9% increase in our annual Medicare FFS IPPS payments, which yields an estimated increase of approximately $35 million. Because of the uncertainty associated with various factors that may influence our future IPPS payments by individual hospital, including legislative or legal actions, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

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

On November 2, 2018, CMS released Changes to the Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year ("CY") 2019 ("Final OPPS/ASC Rule"). The Final OPPS/ASC Rule includes the following payment and policy changes:

- An estimated net increase of 1.35% for the OPPS rates based on an estimated market basket increase of 2.9% reduced by market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.8%, respectively;
- A transition over a two year period to the MPFS rates for the payment of clinic/office visits provided at off-campus, hospital-based departments that are currently paid under the OPPS (this payment reduction will not be made in a budget-neutral manner and will result in a reduction of approximately 0.6% to total CY 2019 OPPS payments);
- A 2.1% increase to the ASC payment rates; and
- A revision to the definition of "surgery" in the ASC payment system to account for certain "surgery-like" procedures, and the addition of 12 cardiac catheterization procedures and five related procedures to the ASC covered procedures list.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS/ASC Rule will yield an average 0.6% increase in Medicare FFS OPPS payments for all hospitals, an average 0.7% increase in Medicare FFS OPPS payments for hospitals in large urban areas (populations over one million), and an average 1.0% 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 $7 million, which represents an increase of approximately 1.1%. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative or legal actions, volumes and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

The 340B program allows certain hospitals (i.e., only nonprofit organizations with specific federal designations and/or funding) to purchase separately-payable drugs at discounted rates from drug manufacturers. In the CY 2018 OPPS Final Rule, CMS reduced the payment for separately payable drugs purchased under the 340B program from average sale price ("ASP") plus 6% to ASP minus 22.5%, and made a corresponding budget-neutral increase to payments to all hospitals for other drugs and services reimbursed under the OPPS. During the three months ended December 31, 2018, the U.S. District Court for the District of Columbia held that the adoption of the 340B payment adjustment in the CY 2018 OPPS Final Rule exceeded CMS' statutory authority. Because of the complexity involved in determining equitable relief for the plaintiffs, the court requested the

parties to submit briefs on the appropriate remedy. CMS may appeal the District Court's decision. The District Court's remedy and/or an unfavorable outcome of any appeal could have an adverse effect on the Company's net revenues and cash flows.

The Medicare Access and CHIP Reauthorization Act of 2015

The MACRA replaced the Medicare Sustainable Growth Rate methodology with a new system for establishing the annual updates to the MPFS that, beginning in 2019, rewards the delivery of high-quality patient care through one of two avenues:

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

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

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

Additionally, the MACRA reduced the restoration of the 3.2% coding and document adjustment to hospital inpatient rates that was expected to be effective in FFY 2018 to 3.0%; as modified by the 21st Century Cures Act, the adjustment will be applied at the rate of 0.4588% for FFY 2018 and 0.5% for FFYs 2019 through 2023.

Less than 1% of the net operating revenue generated by our Hospital Operations and other segment during the year ended December 31, 2018 was related to the MPFS. We are unable to estimate the potential impact of the MACRA; however, the maximum incentive and penalty adjustments could result in an increase or decrease in our annual net revenues of approximately $15 million. Additionally, we cannot predict the effect of the MACRA on our future operations, revenues and cash flows.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On November 23, 2018, the CMS issued a final rule that includes updates to payment policies, payment rates, quality provisions and other policies for services furnished under the MPFS for CY 2019 ("MPFS Final Rule"). With the budget neutrality adjustment to account for changes in Relative Value Units required by law, the final MPFS for 2019 will increase by approximately 0.11%. CMS estimates that the impact of the payment and policy changes in the final rule will result in no change in aggregate payments across all specialties.

The American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 ("ARRA") was enacted to stimulate the U.S. economy. One provision of ARRA provides financial incentives to hospitals and physicians to become "meaningful users" of electronic health records ("EHR"). Hospitals that fail to demonstrate meaningful use of EHR are subject to payment penalties; EHR payment adjustments to physicians automatically terminated effective January 1, 2019. During the year ended December 31, 2018 , we recognized $3 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of certain of our hospitals, employed physicians and Ambulatory Care segment facilities demonstrating meaningful use of certified EHR technology and meeting the criteria for revenue recognition. Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Eligible hospitals must continue to demonstrate meaningful use of EHR technology every year to avoid payment reductions in subsequent years. These reductions, which are based on the market basket update, will continue until a hospital achieves compliance. Should all of our hospitals fail to become meaningful users or fail to continue to demonstrate meaningful use of EHR technology and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of up to approximately $37 million in 2019 and subsequent years.

The complexity of the changes required to our hospitals' systems and the time required to complete the changes could result in some or all of our facilities not being fully compliant and subject to the payment penalties permitted under ARRA. Because of the uncertainties regarding the implementation of HIT, including CMS' future EHR implementation regulations, our ability to achieve compliance and the associated costs, we cannot provide any assurances regarding the aforementioned estimates of incentives or penalties in future periods.

CMS Innovation Models

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of Section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS. The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for communities and lower costs through improvement for our healthcare system. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria.

Bipartisan Budget Act of 2018

In February 2018, the President signed the Bipartisan Budget Act of 2018 ("2018 BBA"), a two-year spending agreement and six-week continuing resolution, into law. The 2018 BBA includes the following measures:

- Four additional years of CHIP funding through FFY 2027, as described above;
- Modifications to the MIPS under the MACRA;
- A reduction to the MPFS conversion factor for CY 2019 from 0.5% to 0.25%; and
- Modifications to the ACA Medicaid DSH payment reductions as follows:
    - elimination of the FFY 2018 and 2019 Medicaid DSH payment reductions;
    - retention of the $4 billion payment reduction in FFY 2020; and
    - an increase to the payment reductions in FFYs 2021 through 2025 to $8 billion.

The ACA reduced federal funding for Medicaid DSH payments under the assumption that hospital uncompensated care costs would decline as insurance coverage increased. Although the reductions were delayed several times, federal DSH payment reductions were slated to begin with a $2 billion reduction in FFY 2018, with additional reductions occurring each year through FFY 2025. The amount of federal DSH funds available to each state, referred to as allotments, will vary based on historical state DSH allotments and the methodology that CMS uses to distribute DSH allotment reductions among states. In notices dated November 3, 2017 and July 6, 2018, CMS released the preliminary DSH allotments of approximately $12 billion for FFYs 2017 and 2018, respectively.

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, 2018 , 2017 and 2016 was $9.213 billion , $9.583 billion and $9.728 billion , respectively. Our top ten managed care payers generated 65% of our managed care net patient service revenues for the year ended December 31, 2018 . National payers generated 43% of our managed care net patient service revenues for the year ended December 31, 2018 . The remainder comes from regional or local payers. At December 31, 2018 and 2017 , 61% and 62% , respectively, of our net accounts receivable for our Hospital Operations and other 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 fee-for-service 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, 2018 , a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million . Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage 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 several years, we have seen these improvements moderate in recent years, and we believe the moderation could continue in future years. In the year ended December 31, 2018 , our commercial managed care net inpatient revenue per admission from the hospitals and related outpatient facilities in our Hospital Operations and other segment was approximately 89% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

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

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant number of

our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts.

Self-pay accounts pose significant collectability problems. At both December 31, 2018 and 2017 , 6% of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our implicit price concessions relates to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. 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 this challenge. For example, our *Compact with Uninsured Patients* (" *Compact* ") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically had been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the *Compact* , the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The following table shows our estimated costs (based on selected operating expenses) of caring for self-pay patients and charity care patients, as well as revenues attributable to Medicaid DSH and other supplemental revenues we recognized, in the years ended December 31, 2018 , 2017 and 2016 .

	Years Ended December 31,		
	2018	2017	2016
Estimated costs for:			
Self-pay patients	$ 640	$ 648	$ 609
Charity care patients	124	121	138
Total	$ 764	$ 769	$ 747
Medicaid DSH and other supplemental revenues	$ 847	$ 864	$ 906

The initial expansion of health insurance coverage resulted in an increase in the number of patients using our facilities with either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage and for persons living in the country who are not permitted to enroll in a health insurance exchange or government healthcare insurance program. In October 2017, the administration announced that reimbursements to insurance companies for ACA cost-sharing reduction ("CSR") plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers

for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, many insurers increased premiums for plans offered on ACA exchanges and a few withdrew entirely from offering plans on some of the exchanges.

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2018 COMPARED TO THE YEAR ENDED DECEMBER 31, 2017

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2018 and 2017 :

	Years Ended December 31,		
	2018	2017	Increase (Decrease)
Net operating revenues:			
Hospital Operations and other	$ 15,285	$ 17,656	$ (2,371)
Ambulatory Care	2,085	1,978	107
Conifer	1,533	1,597	(64)
Inter-segment eliminations	(590)	(618)	28
Net operating revenues before provision for doubtful accounts	18,313	20,613	(2,300)
Less provision for doubtful accounts	—	1,434	(1,434)
Net operating revenues	**18,313**	**19,179**	**(866)**
Equity in earnings of unconsolidated affiliates	**150**	**144**	**6**
Operating expenses:			
Salaries, wages and benefits	8,634	9,274	(640)
Supplies	3,004	3,085	(81)
Other operating expenses, net	4,259	4,570	(311)
Electronic health record incentives	(3)	(9)	6
Depreciation and amortization	802	870	(68)
Impairment and restructuring charges, and acquisition-related costs	209	541	(332)
Litigation and investigation costs	38	23	15
Net gains on sales, consolidation and deconsolidation of facilities	(127)	(144)	17
Operating income	**$ 1,647**	**$ 1,113**	**$ 534**

	Years Ended December 31,		
	2018	2017	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.8 %	0.8 %	— %
Operating expenses:			
Salaries, wages and benefits	47.1 %	48.4 %	(1.3)%
Supplies	16.4 %	16.1 %	0.3 %
Other operating expenses, net	23.3 %	23.8 %	(0.5)%
Electronic health record incentives	— %	— %	— %
Depreciation and amortization	4.4 %	4.5 %	(0.1)%
Impairment and restructuring charges, and acquisition-related costs	1.1 %	2.8 %	(1.7)%
Litigation and investigation costs	0.2 %	0.1 %	0.1 %
Net gains on sales, consolidation and deconsolidation of facilities	(0.7)%	(0.7)%	— %
Operating income	**9.0 %**	**5.8 %**	**3.2 %**

Total net operating revenues decreased by $866 million , or 4.5% , for the year ended December 31, 2018 compared to the year ended December 31, 2017 . Hospital Operations and other and Ambulatory Care net operating revenues and provision for doubtful accounts were impacted by our adoption of ASU 2014-09 effective January 1, 2018. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding material reduction in the amounts presented separately as provision for doubtful accounts. Hospital Operations and other net operating revenues net of implicit price concessions and provision for doubtful accounts decreased by $947 million , or 6.1% , for the year ended December 31, 2018 compared to the same period in 2017 , primarily due to the divestiture or closure of eight hospitals since the beginning of the 2017 period. Ambulatory Care net operating revenues net of implicit price concessions and provision for doubtful accounts increased by $145 million , or 7.5% , for the year ended

December 31, 2018 compared to the prior-year period. This growth was driven by an increase in same-facility net operating revenues of $89 million and an increase from acquisitions of $113 million, partially offset by a decrease of $57 million due to the sale of Aspen. Conifer net operating revenues decreased by $64 million , or 4.0% , for the year ended December 31, 2018 compared to the same period in 2017 . Conifer revenues from third-party customers, which are not eliminated in consolidation, decreased $36 million , or 3.7% , for the year ended December 31, 2018 compared to the prior-year period. Conifer revenues from third-party customers were negatively impacted by contract terminations related to the sales of customer hospitals, partially offset by the impact of the divestiture of former Tenet facilities that have now become third-party customers.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 68 hospitals operated throughout the years ended December 31, 2018 and 2017 . Our same-hospital information excludes the results of three Houston-area hospitals, which we divested effective August 1, 2017 , Abrazo Maryvale Campus, which we closed in December 2017 , two Philadelphia-area hospitals, which we divested effective January 11, 2018 , MacNeal Hospital, which we divested effective March 1, 2018 and Des Peres Hospital, which we divested effective May 1, 2018 . In addition, although we operated four North Texas hospitals throughout the year ended December 31, 2017 and from January 1 through February 28, 2018 as part of a joint venture , we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

	Years Ended December 31,		
Selected Operating Expenses	**2018**	**2017**	**Increase (Decrease)**
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits	$ 7,076	$ 6,952	1.8 %
Supplies	2,538	2,440	4.0 %
Other operating expenses	3,477	3,246	7.1 %
Total	$ 13,091	$ 12,638	3.6 %
Ambulatory Care			
Salaries, wages and benefits	$ 644	$ 623	3.4 %
Supplies	430	398	8.0 %
Other operating expenses	359	360	(0.3)%
Total	$ 1,433	$ 1,381	3.8 %
Conifer			
Salaries, wages and benefits	$ 863	$ 962	(10.3)%
Supplies	5	5	— %
Other operating expenses	308	347	(11.2)%
Total	$ 1,176	$ 1,314	(10.5)%
Total			
Salaries, wages and benefits	$ 8,583	$ 8,537	0.5 %
Supplies	2,973	2,843	4.6 %
Other operating expenses	4,144	3,953	4.8 %
Total	$ 15,700	$ 15,333	2.4 %
Rent/lease expense (1)			
Hospital Operations and other	$ 227	$ 221	2.7 %
Ambulatory Care	80	77	3.9 %
Conifer	17	19	(10.5)%
Total	$ 324	$ 317	2.2 %

(1) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported in three segments:

- Hospital Operations and other, which is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 5 to the accompanying Consolidated Financial Statements , certain of our facilities were classified as held for sale at December 31, 2018 .

- Ambulatory Care, which is comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals (and also included nine facilities in the United Kingdom until we divested Aspen effective August 17, 2018).

- Conifer, which provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities .

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals and related outpatient facilities on a same-hospital basis, unless otherwise indicated, which includes the results of our same 68 hospitals operated throughout the years ended December 31, 2018 and 2017 . Our same-hospital information excludes the results of three Houston-area hospitals, which we divested effective August 1, 2017 , Abrazo Maryvale Campus, which we closed in December 2017 , two Philadelphia-area hospitals, which we divested effective January 11, 2018 , MacNeal Hospital, which we divested effective March 1, 2018 , and Des Peres Hospital, which we divested effective May 1, 2018 . In addition, although we operated four North Texas hospitals throughout the year ended December 31, 2017 and from January 1 through February 28, 2018 as part of a joint venture , we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

	Same-Hospital Continuing Operations			
	Years Ended December 31,			
Admissions, Patient Days and Surgeries	**2018**	**2017**	**Increase (Decrease)**	
Number of hospitals (at end of period)	68	68	—	(1)
Total admissions	684,933	696,590	(1.7)%	
Adjusted patient admissions (2)	1,232,150	1,232,200	— %	
Paying admissions (excludes charity and uninsured)	643,828	658,296	(2.2)%	
Charity and uninsured admissions	41,105	38,294	7.3 %	
Admissions through emergency department	474,606	454,364	4.5 %	
Paying admissions as a percentage of total admissions	94.0%	94.5%	(0.5)%	(1)
Charity and uninsured admissions as a percentage of total admissions	6.0%	5.5%	0.5 %	(1)
Emergency department admissions as a percentage of total admissions	69.3%	65.2%	4.1 %	(1)
Surgeries — inpatient	183,520	188,853	(2.8)%	
Surgeries — outpatient	248,770	250,726	(0.8)%	
Total surgeries	432,290	439,579	(1.7)%	
Patient days — total	3,148,094	3,220,528	(2.2)%	
Adjusted patient days (2)	5,569,440	5,605,146	(0.6)%	
Average length of stay (days)	4.60	4.62	(0.4)%	
Licensed beds (at end of period)	17,937	17,946	(0.1)%	
Average licensed beds	17,940	17,980	(0.2)%	
Utilization of licensed beds (3)	48.1%	49.1%	(1.0)%	(1)

(1) The change is the difference between 2018 and 2017 amounts shown.

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

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

Outpatient Visits	Same-Hospital Continuing Operations Years Ended December 31, 2018	2017	Increase (Decrease)	
Total visits	6,999,028	7,064,412	(0.9)%	
Paying visits (excludes charity and uninsured)	6,537,366	6,605,226	(1.0)%	
Charity and uninsured visits	461,662	459,186	0.5 %	
Emergency department visits	2,613,018	2,583,612	1.1 %	
Surgery visits	248,770	250,726	(0.8)%	
Paying visits as a percentage of total visits	93.4%	93.5%	(0.1)%	(1)
Charity and uninsured visits as a percentage of total visits	6.6%	6.5%	0.1 %	(1)

(1) The change is the difference between the 2018 and 2017 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2018	2017	Increase (Decrease)
Total segment net operating revenues (1)	$ 14,516	$ 14,011	3.6%
Selected revenue data – hospitals and related outpatient facilities			
Net patient service revenues (1)(2)	$ 13,995	$ 13,514	3.6%
Net patient service revenue per adjusted patient admission (1)(2)	$ 11,358	$ 10,967	3.6%
Net patient service revenue per adjusted patient day (1)(2)	$ 2,513	$ 2,411	4.2%

(1) Revenues are net of implicit price concessions and provision for doubtful accounts.

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

Total Segment Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2018	2017	Increase (Decrease)	
Salaries, wages and benefits as a percentage of net operating revenues	48.7%	49.6%	(0.9)%	(1)
Supplies as a percentage of net operating revenues	17.5%	17.4%	0.1 %	(1)
Other operating expenses as a percentage of net operating revenues	24.0%	23.2%	0.8 %	(1)

(1) The change is the difference between the 2018 and 2017 amounts shown.

Revenues

Same-hospital net operating revenues increased $505 million , or 3.6% , during the year ended December 31, 2018 compared to the year ended December 31, 2017 , primarily due improved terms of our managed care contracts. Same-hospital admissions decreased 1.7% in the year ended December 31, 2018 compared to the prior-year period. Same-hospital outpatient visits decreased 0.9% in the year ended December 31, 2018 compared to the prior-year period.

The following table shows the consolidated net accounts receivable by payer at December 31, 2018 and the consolidated net accounts receivable and allowance for doubtful accounts by payer at December 31, 2017:

	December 31, 2018	December 31, 2017		
	Accounts Receivable	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 229	$ 257	$ —	$ 257
Medicaid	74	95	—	95
Net cost report settlements receivable and valuation allowances	18	4	—	4
Managed care	1,467	1,709	204	1,505
Self-pay uninsured	47	407	351	56
Self-pay balance after insurance	94	240	149	91
Estimated future recoveries	148	132	—	132
Other payers	325	453	151	302
Total Hospital Operations and other	2,402	3,297	855	2,442
Ambulatory Care	191	215	43	172
Total discontinued operations	2	2	—	2
	$ 2,595	**$ 3,514**	**$ 898**	**$ 2,616**

For patient accounts receivable resulting from revenue recognized prior to January 1, 2018, an allowance for doubtful accounts was established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimated this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. Under the provisions of ASU 2014-09, which we adopted effective January 1, 2018, when we have an unconditional right to payment, subject only to the passage of time, the right is treated as a receivable. Patient accounts receivable, including billed accounts and unbilled accounts for which we have the unconditional right to payment, and 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. For patient accounts receivable subsequent to our adoption of ASU 2014-09 on January 1, 2018, the estimated uncollectable amounts are generally considered implicit price concessions that are a direct reduction to patient accounts receivable rather than allowance for doubtful accounts. Under the provisions of ASU 2014-09, 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 and other segment, our contract assets consist primarily of 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 and other segment's contract assets are included in other current assets in the accompanying Consolidated Balance Sheet at December 31, 2018. Prior to January 1, 2018, amounts related to services provided to patients for which we had not billed were included in accounts receivable, less allowance for doubtful accounts, in our consolidated balance sheets.

Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2018 , our Hospital Operations and other segment collection rate on self-pay accounts was approximately 23.1% . 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 self-pay patients and co-pays, co-insurance amounts and deductibles owed to us by patients with insurance at December 31, 2018 , a 10% decrease or increase in our self-pay collection rate, or approximately 2% , which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to patient accounts receivable of approximately $11 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 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 and other segment collection rate from managed care payers was approximately 98.3% at December 31, 2018 .

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 and other segment of $2.384 billion and $2.438 billion at December 31, 2018 and 2017 , respectively, excluding cost report settlements receivable and valuation allowances of $18 million and $4 million , respectively, at December 31, 2018 and 2017 :

	December 31, 2018				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days (1)	89%	51%	60%	29%	56%
61-120 days	6%	24%	14%	18%	15%
121-180 days	2%	10%	8%	11%	8%
Over 180 days	3%	15%	18%	42%	21%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

(1) The 0-60 days aging category has been impacted by the reclassification of certain unbilled accounts to contract assets due to the adoption of ASU 2014-09 effective January 1, 2018. See Notes 1 and 4 to our accompanying Consolidated Financial Statements for additional information.

	December 31, 2017				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	89%	66%	65%	28%	60%
61-120 days	6%	16%	14%	17%	13%
121-180 days	2%	10%	7%	9%	7%
Over 180 days	3%	8%	14%	46%	20%
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, 2018 , we had a cumulative total of patient account assignments to Conifer of $2.546 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to Conifer is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medicaid Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. Based on recent trends, approximately 97% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2018 and 2017 by aging category for the hospitals currently in the program:

	December 31,	
	2018	2017
0-60 days	$ 72	$ 81
61-120 days	16	12
121-180 days	3	3
Over 180 days	5	4
Total	**$ 96**	**$ 100**

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased by 90 basis points to 48.7% in the year ended December 31, 2018 compared to the prior-year period. Same-hospital net operating revenues increased 3.6% in the year ended December 31, 2018 compared to the year ended December 31, 2017 , and same-hospital salaries, wages and benefits increased by 1.8% in the 2018 period compared to the 2017 period. The change in same-hospital salaries, wages and benefits as a percentage of net operating revenues was primarily due to an increase in same-hospital net operating revenues and the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives, partially offset by increased health benefits costs and annual merit increases for certain of our employees. Salaries, wages and benefits expense for the years ended December 31, 2018 and 2017 included stock-based compensation expense of $25 million and $46 million , respectively.

Supplies

Same-hospital supplies expense as a percentage of net operating revenues increased by 10 basis points to 17.5% in the year ended December 31, 2018 compared to the 2017 period. Supplies expense was impacted by increased costs from certain higher acuity supply-intensive surgical services, partially offset by the benefits of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

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 continue to be cardiac stents and pacemakers, orthopedics, implants, and high-cost pharmaceuticals.

Other Operating Expenses, Net

Same-hospital other operating expenses as a percentage of net operating revenues increased by 80 basis points to 24.0% in the year ended December 31, 2018 compared to 23.2% in the 2017 period. Same-hospital other operating expenses increased by $231 million , or 7.1% , for the year ended December 31, 2018 compared to the year ended December 31, 2017 . The changes in other operating expenses included:

- increased malpractice expense of $115 million to settle various claims; and
- increased medical fees of $89 million , due in part to unfavorable claims experience on risk-based capitated contracts in California, partially offset by
- decreased expenses associated with our health plan businesses of $95 million due to the sale and wind-down of those businesses in 2017, which decreases were offset by decreased health plan revenues.

Same-hospital malpractice expense in the 2018 period included a favorable adjustment of approximately $10 million from a 26 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to approximately $3 million from an eight basis point increase in the interest rate in the 2017 period.

Ambulatory Care Segment

Our Ambulatory Care segment is comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals. Our Ambulatory Care segment also included nine facilities in the United Kingdom until we divested Aspen effective August 17, 2018. USPI operates its surgical facilities in partnership with local physicians and, in many of these facilities, a healthcare system partner. We hold an ownership interest in each facility, with each being operated through a separate legal entity in most cases. USPI operates facilities on a day-to-day basis through management services contracts. Our sources of earnings from each facility consist of:

- management services revenues, computed as a percentage of each facility's net revenues (often net of implicit price concessions); and
- our share of each facility's net income (loss), which is computed by multiplying the facility's net income (loss) times the percentage of each facility's equity interests owned by USPI.

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. For many of the facilities our Ambulatory Care segment operates (110 of 337 facilities at December 31, 2018), 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 227 of the facilities our Ambulatory Care segment operates, and we account for these investments as consolidated subsidiaries. Our net earnings from a facility are the same under either method, but the classification of those earnings differs. For consolidated subsidiaries, our financial statements reflect 100% of the revenues and expenses of the subsidiaries, after the elimination of intercompany amounts. The net profit attributable to owners other than USPI is classified within "net income available to noncontrolling interests."

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

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

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

Our Ambulatory Care segment operating income is driven by the performance of all facilities USPI operates and by USPI's ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 67% 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, 2018 Compared to the Year Ended December 31, 2017

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

	Years Ended December 31,		
Ambulatory Care Results of Operations	**2018**	**2017**	**Increase (Decrease)**
Net operating revenues	$ 2,085	$ 1,940	7.5 %
Equity in earnings of unconsolidated affiliates	$ 140	$ 140	— %
Salaries, wages and benefits	$ 644	$ 623	3.4 %
Supplies	$ 430	$ 398	8.0 %
Other operating expenses, net	$ 359	$ 360	(0.3)%

Our Ambulatory Care net operating revenues increased by $145 million , or 7.5% , for the year ended December 31, 2018 compared to the year ended December 31, 2017 . This growth was driven by an increase in same-facility net operating revenues of $89 million and an increase from acquisitions of $113 million, partially offset by a decrease of $57 million due to the sale of Aspen.

Salaries, wages and benefits expense increased by $21 million , or 3.4% , for the year ended December 31, 2018 compared to the year ended December 31, 2017 . The change was driven by an increase in same-facility salaries, wages and benefits expense of $20 million and an increase from acquisitions of $22 million, partially offset by a decrease of $21 million due to the sale of Aspen.

Supplies expense increased by $32 million , or 8.0% , for the year ended December 31, 2018 compared to the year ended December 31, 2017 . The change was driven by an increase in same-facility supplies expense of $26 million and an increase from acquisitions of $18 million, partially offset by a decrease of $12 million due to the sale of Aspen.

Other operating expenses decreased by $1 million , or 0.3% , for the year ended December 31, 2018 compared to the year ended December 31, 2017 . Other operating expenses in 2018 were impacted by an increase in same-facility other operating expenses of $1 million, an increase from acquisitions of $14 million and a decrease of $16 million due to the sale of Aspen.

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, 2018
Net revenues	5.1%
Cases	3.4%
Net revenue per case	1.6%

Joint Ventures with Healthcare 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 healthcare system partner. Accordingly, as of December 31, 2018 , the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities	Year Ended December 31, 2018
Facilities:	
With a healthcare system partner	208
Without a healthcare system partner	129
Total facilities operated	337
Change from December 31, 2017	
Acquisitions	10
De novo	8
Dispositions/Mergers	(14)
Total increase in number of facilities operated	4

During the year ended December 31, 2018 , we sold our nine Aspen facilities in the United Kingdom, and we acquired controlling interests in an ophthalmology surgery center in Pennsylvania, a single-specialty spine surgery center in Georgia, two multi-specialty surgery centers in Florida and one in Texas, and a single specialty gastroenterology center in Florida. We paid cash totaling $97 million for these acquisitions. We also acquired noncontrolling ownership interests in a multi-specialty surgery center in California and two surgical hospitals in Oklahoma for $88 million . All nine facilities are jointly owned with local physicians, and four of them have a healthcare system partner.

Also during the year ended December 31, 2018 , we acquired controlling interests in four facilities in which we already had an equity method investment. These multi-specialty surgery centers are located in New Jersey and Georgia. We paid cash totaling $7 million for the additional ownership interests. All four facilities are jointly owned with local physicians and a healthcare system partner. Furthermore, during the year ended December 31, 2018 , the Ambulatory Care segment acquired the non-controlling interest in Baylor Scott & White Medical Center – Sunnyvale, a surgical hospital in Texas, previously held by the Hospital Operations and other segment. The facility is jointly owned with local physicians and a healthcare system partner.

We also regularly engage in the purchase of equity interests with respect to our investments in unconsolidated affiliates and consolidated facilities that do not result in a change of control. These transactions are primarily the acquisitions of equity interests in ambulatory care facilities and the investment of additional cash in facilities that need capital for acquisitions, new construction or other business growth opportunities. During the year ended December 31, 2018, we invested approximately $36 million in such transactions.

Conifer Segment

Our Conifer segment generated net operating revenues of $1.533 billion and $1.597 billion during the years ended December 31, 2018 and 2017 , respectively, a portion of which was eliminated in consolidation as described in Note 22 to the Consolidated Financial Statements. Conifer revenues from third-party customers, which are not eliminated in consolidation, decreased $36 million , or 3.7% , for the year ended December 31, 2018 compared to the prior-year period. Conifer revenues

from third-party customers were negatively impacted by contract terminations related to the sales of customer hospitals, partially offset by the impact of the divestiture of former Tenet facilities that have now become third-party customers.

Salaries, wages and benefits expense for Conifer decreased $99 million , or 10.3% , in the year ended December 31, 2018 compared to the year ended December 31, 2017 primarily due to the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives.

Other operating expenses for Conifer decreased $39 million , or 11.2% , in the year ended December 31, 2018 compared to the year ended December 31, 2017 primarily due to the impact of our enterprise-wide cost reduction initiatives.

The agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer, were initially scheduled to expire in December 2018. As we continue to pursue strategic alternatives for Conifer, these agreements were renewed for an additional year with substantially similar pricing terms; however, the pricing or other material terms of such agreements may be modified if any such strategic alternative is consummated. Conifer's contract with Tenet represented 38.5% of the net operating revenues Conifer recognized in the year ended December 31, 2018 .

Consolidated

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the year ended December 31, 2018 , we recorded impairment and restructuring charges and acquisition-related costs of $209 million , consisting of $77 million of impairment charges , $115 million of restructuring charges and $17 million of acquisition-related costs. Impairment charges included $40 million for the write-down of buildings and other long-lived assets to their estimated fair values at two hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $130 million at December 31, 2018 after recording the impairment charges. We also recorded $24 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities , $9 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $4 million of other impairment charges. Restructuring charges consisted of $68 million of employee severance costs , $17 million of contract and lease termination fees , and $30 million of other restructuring costs . Acquisition-related costs consisted of $10 million of transaction costs and $7 million of acquisition integration charges . Our impairment and restructuring charges and acquisition-related costs for the year ended December 31, 2018 were comprised of $141 million from our Hospital Operations and other segment, $28 million from our Ambulatory Care segment and $40 million from our Conifer segment.

During the year ended December 31, 2017 , we recorded impairment and restructuring charges and acquisition-related costs of $541 million , consisting of $402 million of impairment charges, $117 million of restructuring charges and $22 million of acquisition-related costs. Impairment charges consisted of $364 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen, our Philadelphia-area facilities and certain of our Chicago-area facilities, $31 million for the impairment of two equity method investments and $7 million to write-down intangible assets. Restructuring charges consisted of $82 million of employee severance costs, $15 million of contract and lease termination fees, and $20 million of other restructuring costs. Acquisition-related costs consisted of $6 million of transaction costs and $16 million of acquisition integration charges. Our impairment and restructuring charges and acquisition-related costs for the year ended December 31, 2017 were comprised of $446 million from our Hospital Operations and other segment, $74 million from our Ambulatory Care segment and $21 million from our Conifer segment.

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

Litigation and Investigation Costs

Litigation and investigation costs for the years ended December 31, 2018 and 2017 were $38 million and $23 million , respectively. The increased costs in the 2018 period relate primarily to attorneys' fees associated with internal investigations performed pursuant to our Non-Prosecution Agreement (the "NPA"), as well as attorneys' fees associated with our indemnification obligations with respect to two former employees in connection with criminal charges for conduct described in the NPA.

Net Gains on Sales, Consolidation and Deconsolidation of Facilities

During the year ended December 31, 2018 , we recorded net gains on sales, consolidation and deconsolidation of facilities of $127 million , primarily comprised of gains of $36 million from the sale of our health plan in California, $90 million from the sale of MacNeal Hospital and other operations affiliated with the hospital in the Chicago area, $11 million from the sales of our minority interests in four North Texas hospitals and $12 million from the sale of Des Peres Hospital, physician practices and other hospital-affiliated operations in St. Louis, Missouri, as well as net gains on sales, consolidation and deconsolidation of $8 million from our Ambulatory Care segment, partially offset by losses of $21 million from the sale of our hospitals, physician practices and related assets in Philadelphia, Pennsylvania and the surrounding area, and $10 million due to post-closing adjustments related to the sale of our hospitals, physician practices and related assets in Houston, Texas and the surrounding area.

During the year ended December 31, 2017 , we recorded gains on sales, consolidation and deconsolidation of facilities of $144 million , primarily comprised of an $111 million gain from the sale of our hospitals, physician practices and related assets in Houston, Texas and the surrounding area, $13 million from the sale of the membership of one of our health plans in Arizona, $10 million from the sale of our health plan membership in Texas, $3 million from the sale of our health plan in Michigan, and $9 million of gains related to the consolidation of certain USPI businesses due to ownership changes.

Interest Expense

Interest expense for the year ended December 31, 2018 was $1.004 billion compared to $1.028 billion for the year ended December 31, 2017 .

Income Tax Expense

During the year ended December 31, 2018 , we recorded income tax expense of $176 million in continuing operations on pre-tax income of $639 million compared to income tax expense of $219 million in continuing operations on a pre-tax loss of $101 million during the year ended December 31, 2017 . 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,	
	2018	**2017**
Tax expense (benefit) at statutory federal rate of 21% in 2018 (35% in 2017)	$ 134	$ (35)
State income taxes, net of federal income tax benefit	23	4
Expired state net operating losses, net of federal income tax benefit	9	28
Tax attributable to noncontrolling interests	(70)	(113)
Nondeductible goodwill	8	109
Impact of decrease in federal tax rate on deferred taxes	(1)	246
Reversal of permanent reinvestment assumption and other adjustments related to divestiture of foreign subsidiary	(6)	(30)
Stock-based compensation tax deficiencies	5	15
Changes in valuation allowance (including impact of decrease in federal tax rate)	76	—
Change in tax contingency reserves, including interest	(1)	(6)
Prior-year provision to return adjustments and other changes in deferred taxes	(5)	4
Other items	4	(3)
Income tax expense	**$ 176**	**$ 219**

In December 2017, the President signed into law the Tax Cuts and Jobs Act (the "Tax Act"). The Tax Act amended the Internal Revenue Code to reduce tax rates and modify policies, credits and deductions for individuals and businesses. For businesses, the Tax Act made broad and complex changes to the U.S. tax code, including but not limited to (1) reducing the corporate federal tax rate from a maximum of 35% to a flat 21% rate effective January 1, 2018, (2) repealing the corporate

alternative minimum tax ("AMT") and changing how existing AMT credits may be realized, (3) creating a new limitation on the deductibility of interest expense, (4) allowing full expensing of certain capital expenditures, and (5) denying deductions for performance-based compensation paid to certain key executives. International provisions in the Tax Act have not had, and are not expected to have, a material impact on the Company's taxes.

As a result of the reduction in the corporate income tax rate from 35% to 21% under the Tax Act, we revalued our net deferred tax assets at December 31, 2017, resulting in a reduction in the value of our net deferred tax assets by $251 million . For the year ended December 31, 2017, we recorded $252 million as a provisional estimate of the impact of the Tax Act, including the decrease in the corporate income tax rate from 35% to 21%. Approximately $6 million of the total $252 million increase in income tax expense is included in the net change in valuation allowance, with the remaining $246 million shown in the table above. During the year ended December 31, 2018 , we recorded $1 million of tax benefit upon finalizing our accounting for income tax effects of the Tax Act based on actual 2017 federal and state income tax filings.

Net Income Available to Noncontrolling Interests

Net income available to noncontrolling interests was $355 million for the year ended December 31, 2018 compared to $384 million for the year ended December 31, 2017 . Net income available (loss attributable) to noncontrolling interests in the 2018 period was comprised of $(17) million related to our Hospital Operations and other segment, $308 million related to our Ambulatory Care segment and $64 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $20 million 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 defined by the Company as net income available (loss attributable) to Tenet Healthcare Corporation common shareholders before (1) the cumulative effect of changes in accounting principle, (2) net loss attributable (income available) to noncontrolling interests, (3) income (loss) from discontinued operations, (4) income tax benefit (expense), (5) gain (loss) from early extinguishment of debt, (6) other non-operating 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 operations and closed businesses (i.e., our health plan businesses). Litigation and investigation costs do not include ordinary course of business malpractice and other litigation and related expense.

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

The following table shows the reconciliation of Adjusted EBITDA to net income available (loss attributable) to Tenet Healthcare Corporation common shareholders (the most comparable GAAP term) for the years ended December 31, 2018 and 2017 :

	Years Ended December 31,	
	2018	2017
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 111**	**$ (704)**
Less: Net income available to noncontrolling interests	(355)	(384)
Income (loss) from discontinued operations, net of tax	3	—
Income (loss) from continuing operations	463	(320)
Income tax expense	(176)	(219)
Gain (loss) from early extinguishment of debt	1	(164)
Other non-operating expense, net	(5)	(22)
Interest expense	(1,004)	(1,028)
Operating income	1,647	1,113
Litigation and investigation costs	(38)	(23)
Net gains on sales, consolidation and deconsolidation of facilities	127	144
Impairment and restructuring charges, and acquisition-related costs	(209)	(541)
Depreciation and amortization	(802)	(870)
Income (loss) from divested and closed businesses (i.e., the Company ' s health plan businesses)	9	(41)
Adjusted EBITDA	**$ 2,560**	**$ 2,444**
Net operating revenues	**$ 18,313**	**$ 19,179**
Less: Net operating revenues from health plans	**14**	**110**
Adjusted net operating revenues	**$ 18,299**	**$ 19,069**
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders as a % of net operating revenues	**0.6%**	**(3.7)%**
Adjusted EBITDA as % of adjusted net operating revenues (Adjusted EBITDA margin)	**14.0%**	**12.8 %**

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2017 COMPARED TO THE YEAR ENDED DECEMBER 31, 2016

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2017 and 2016 :

	Years Ended December 31,		
	2017	2016	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 16,242	$ 16,488	$ (246)
Other operations	4,371	4,582	(211)
Net operating revenues before provision for doubtful accounts	20,613	21,070	(457)
Less provision for doubtful accounts	1,434	1,449	(15)
Net operating revenues	**19,179**	**19,621**	**(442)**
Equity in earnings of unconsolidated affiliates	**144**	**131**	**13**
Operating expenses:			
Salaries, wages and benefits	9,274	9,328	(54)
Supplies	3,085	3,124	(39)
Other operating expenses, net	4,570	4,891	(321)
Electronic health record incentives	(9)	(32)	23
Depreciation and amortization	870	850	20
Impairment and restructuring charges, and acquisition-related costs	541	202	339
Litigation and investigation costs	23	293	(270)
Gains on sales, consolidation and deconsolidation of facilities	(144)	(151)	7
Operating income	**$ 1,113**	**$ 1,247**	**$ (134)**

	Years Ended December 31,		
	2017	2016	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.8 %	0.7 %	0.1 %
Operating expenses:			
Salaries, wages and benefits	48.4 %	47.5 %	0.9 %
Supplies	16.1 %	15.9 %	0.2 %
Other operating expenses, net	23.8 %	25.0 %	(1.2)%
Electronic health record incentives	— %	(0.2)%	0.2 %
Depreciation and amortization	4.5 %	4.3 %	0.2 %
Impairment and restructuring charges, and acquisition-related costs	2.8 %	1.1 %	1.7 %
Litigation and investigation costs	0.1 %	1.5 %	(1.4)%
Gains on sales, consolidation and deconsolidation of facilities	(0.7)%	(0.8)%	0.1 %
Operating income	**5.8 %**	**6.4 %**	**(0.6)%**

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations for the periods presented primarily consist of revenues from (1) physician practices, (2) our Ambulatory Care segment, (3) services provided by Conifer to third parties and (4) our health plans, most of which were sold in 2017. Revenues from our general hospitals represented approximately 79% and 78% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2017 and 2016 , respectively.

Net operating revenues from our other operations were $4.371 billion and $4.582 billion in the years ended December 31, 2017 and 2016 , respectively. The decrease in net operating revenues from other operations during 2017 primarily related to the cessation of operations of our health plan businesses in 2017, partially offset by increased revenues from the revenue cycle services provided by Conifer, as well as revenues from USPI. Equity in earnings of unconsolidated affiliates were $144 million and $131 million for the years ended December 31, 2017 and 2016 , respectively. The increase in equity in earnings of unconsolidated affiliates in the 2017 period compared to the 2016 period primarily related to USPI.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 72 hospitals operated throughout the years ended December 31, 2017 and 2016 . Our same-hospital information excludes the results of five Georgia hospitals, which we divested effective April 1, 2016, our THOP Transmountain Campus teaching hospital, which we opened in January 2017 in El Paso, and three Houston-area hospitals, which we divested effective August 1, 2017. In addition, although we operated four North Texas hospitals throughout the years ended December 31, 2017 and 2016, we do not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

	Years Ended December 31,		
Selected Operating Expenses	2017	2016	Increase (Decrease)
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits	$ 7,490	$ 7,423	0.9 %
Supplies	2,628	2,659	(1.2)%
Other operating expenses	3,682	3,936	(6.5)%
Total	$ 13,800	$ 14,018	(1.6)%
Ambulatory Care			
Salaries, wages and benefits	$ 623	$ 594	4.9 %
Supplies	398	365	9.0 %
Other operating expenses	360	346	4.0 %
Total	$ 1,381	$ 1,305	5.8 %
Conifer			
Salaries, wages and benefits	$ 962	$ 959	0.3 %
Supplies	5	—	100.0 %
Other operating expenses	347	335	3.6 %
Total	$ 1,314	$ 1,294	1.5 %
Total			
Salaries, wages and benefits	$ 9,075	$ 8,976	1.1 %
Supplies	3,031	3,024	0.2 %
Other operating expenses	4,389	4,617	(4.9)%
Total	$ 16,495	$ 16,617	(0.7)%
Rent/lease expense (1)			
Hospital Operations and other	$ 226	$ 223	1.3 %
Ambulatory Care	77	74	4.1 %
Conifer	19	18	5.6 %
Total	$ 322	$ 315	2.2 %

(1) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

At December 31, 2017, our operations were reported in three segments:

- Hospital Operations and other, which was comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 5 to the accompanying Consolidated Financial Statements, certain of our facilities were classified as held for sale at December 31, 2017 .

- Ambulatory Care, which was comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals, as well as Aspen's hospitals and clinics, which were classified as held for sale at December 31, 2017 as described in Note 5 to the accompanying Consolidated Financial Statements.

- Conifer, which provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals and related outpatient facilities on a same-hospital basis, unless otherwise indicated, which includes the results of our same 72 hospitals operated throughout the years ended December 31, 2017 and 2016. Our same-hospital information excludes the results of five Georgia hospitals, which we divested effective April 1, 2016, our THOP Transmountain Campus teaching hospital, which we opened in January 2017 in El Paso, and three Houston-area hospitals, which we divested effective August 1, 2017. In addition, although we operated four North Texas hospitals throughout the years ended December 31, 2017 and 2016, we do not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

	Same-Hospital Continuing Operations			
	Years Ended December 31,			
Admissions, Patient Days and Surgeries	**2017**	**2016**	**Increase (Decrease)**	
Number of hospitals (at end of period)	72	72	—	(1)
Total admissions	738,528	753,673	(2.0)%	
Adjusted patient admissions (2)	1,294,913	1,310,962	(1.2)%	
Paying admissions (excludes charity and uninsured)	699,613	715,198	(2.2)%	
Charity and uninsured admissions	38,915	38,475	1.1 %	
Admissions through emergency department	480,180	476,068	0.9 %	
Paying admissions as a percentage of total admissions	94.7%	94.9%	(0.2)%	(1)
Charity and uninsured admissions as a percentage of total admissions	5.3%	5.1%	0.2 %	(1)
Emergency department admissions as a percentage of total admissions	65.0%	63.2%	1.8 %	(1)
Surgeries — inpatient	199,871	207,609	(3.7)%	
Surgeries — outpatient	271,228	286,761	(5.4)%	
Total surgeries	471,099	494,370	(4.7)%	
Patient days — total	3,423,934	3,515,087	(2.6)%	
Adjusted patient days (2)	5,964,002	6,080,456	(1.9)%	
Average length of stay (days)	4.64	4.66	(0.4)%	
Licensed beds (at end of period)	19,035	19,306	(1.4)%	
Average licensed beds	19,277	19,315	(0.2)%	
Utilization of licensed beds (3)	48.7%	49.9%	(1.2)%	(1)

(1) The change is the difference between 2017 and 2016 amounts shown.

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

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

	Same-Hospital Continuing Operations			
	Years Ended December 31,			
Outpatient Visits	**2017**	**2016**	**Increase (Decrease)**	
Total visits	7,495,754	7,697,302	(2.6)%	
Paying visits (excludes charity and uninsured)	7,028,688	7,200,453	(2.4)%	
Charity and uninsured visits	467,066	496,849	(6.0)%	
Emergency department visits	2,664,448	2,689,519	(0.9)%	
Surgery visits	271,228	286,761	(5.4)%	
Paying visits as a percentage of total visits	93.8%	93.5%	0.3 %	(1)
Charity and uninsured visits as a percentage of total visits	6.2%	6.5%	(0.3)%	(1)

(1) The change is the difference between the 2017 and 2016 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2017	2016	Increase (Decrease)
Total segment net operating revenues	$ 15,191	$ 15,472	(1.8)%
Selected acute care hospitals and related outpatient facilities revenue data			
Net inpatient revenues	$ 10,037	$ 10,089	(0.5)%
Net outpatient revenues	5,626	5,452	3.2 %
Net patient revenues	$ 15,663	$ 15,541	0.8 %
Self-pay net inpatient revenues	$ 395	$ 370	6.8 %
Self-pay net outpatient revenues	564	511	10.4 %
Total self-pay revenues	$ 959	$ 881	8.9 %

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2017	2016	Increase (Decrease)
Net inpatient revenue per admission	$ 13,591	$ 13,386	1.5%
Net inpatient revenue per patient day	$ 2,931	$ 2,870	2.1%
Net outpatient revenue per visit	$ 751	$ 708	6.1%
Net patient revenue per adjusted patient admission (1)	$ 12,096	$ 11,855	2.0%
Net patient revenue per adjusted patient day (1)	$ 2,626	$ 2,556	2.7%

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

Total Segment Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2017	2016	Increase (Decrease)	
Provision for doubtful accounts	$ 1,300	$ 1,220	6.6%	
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.9%	7.3%	0.6%	(1)

(1) The change is the difference between the 2017 and 2016 amounts shown.

Total Segment Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2017	2016	Increase (Decrease)	
Salaries, wages and benefits as a percentage of net operating revenues	49.3%	48.0%	1.3 %	(1)
Supplies as a percentage of net operating revenues	17.3%	17.2%	0.1 %	(1)
Other operating expenses as a percentage of net operating revenues	24.2%	25.4%	(1.2)%	(1)

(1) The change is the difference between the 2017 and 2016 amounts shown.

Revenues

Same-hospital net operating revenues decreased $281 million , or 1.8% , during the year ended December 31, 2017 compared to the year ended December 31, 2016 . The decrease in same-hospital net operating revenues in the 2017 period is primarily due to lower inpatient and outpatient volumes, as well as a decrease in our other operations revenues, partially offset by improved terms of our managed care contracts and incremental net revenues from the California provider fee program of $35 million . Same-hospital net inpatient revenues decreased $52 million , or 0.5% , while same-hospital admissions decreased 2.0% in the 2017 period compared to the 2016 period. Same-hospital net inpatient revenue per admission increased 1.5% , primarily due to the improved terms of our managed care contracts and volume growth in higher acuity service lines in the year ended December 31, 2017 compared to the prior year. Same-hospital net outpatient revenues increased $174 million , or 3.2% , and same-hospital outpatient visits decreased 2.6% in the year ended December 31, 2017 compared to the year ended

December 31, 2016 . Growth in outpatient revenues was primarily driven by improved terms of our managed care contracts, partially offset by decreased outpatient volume levels. Same-hospital net outpatient revenue per visit increased 6.1% primarily due to the improved terms of our managed care contracts.

Provision for Doubtful Accounts

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.9% and 7.3% for the years ended December 31, 2017 and 2016, respectively. The increase in the 2017 period compared to the 2016 period was driven by increases in uninsured revenues and volumes, as well as higher patient co-pays and deductibles. The following table shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2017 and 2016:

	December 31, 2017			December 31, 2016		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 257	$ —	$ 257	$ 294	$ —	$ 294
Medicaid	95	—	95	125	—	125
Net cost report settlements receivable (payable) and valuation allowances	4	—	4	(14)	—	(14)
Managed care	1,709	204	1,505	1,911	190	1,721
Self-pay uninsured	407	351	56	479	412	67
Self-pay balance after insurance	240	149	91	226	147	79
Estimated future recoveries	132	—	132	141	—	141
Other payers	453	151	302	537	239	298
Total Hospital Operations and other	3,297	855	2,442	3,699	988	2,711
Ambulatory Care	215	43	172	227	43	184
Total discontinued operations	2	—	2	2	—	2
	$ 3,514	**$ 898**	**$ 2,616**	**$ 3,928**	**$ 1,031**	**$ 2,897**

A significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2017 , our Hospital Operations and other segment collection rate on self-pay accounts was approximately 24.7% . This self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2017 , a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million . Our estimated Hospital Operations and other segment collection rate from managed care payers was approximately 97.4% at December 31, 2017 .

The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations and other segment of $2.438 billion and $2.725 billion at December 31, 2017 and 2016 , respectively, excluding cost report settlements receivable (payable) and valuation allowances of $4 million and $(14) million at December 31, 2017 and 2016 , respectively:

	December 31, 2017				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	89%	66%	65%	28%	60%
61-120 days	6%	16%	14%	17%	13%
121-180 days	2%	10%	7%	9%	7%
Over 180 days	3%	8%	14%	46%	20%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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

At December 31, 2017 , we had a cumulative total of patient account assignments to Conifer of approximately $2.279 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to Conifer is determined based on our historical experience and recorded in accounts receivable.

The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2017 and 2016 by aging category for the hospitals currently in the program:

	2017	2016
0-60 days	$ 81	$ 84
61-120 days	12	13
121-180 days	3	4
Over 180 days	4	4
Total	**$ 100**	**$ 105**

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits as a percentage of net operating revenues increased by 130 basis points to 49.3% in the year ended December 31, 2017 compared to the same period in 2016 . While same-hospital net operating revenues decreased 1.8% in the year ended December 31, 2017 compared to the year ended December 31, 2016 , same-hospital salaries, wages and benefits increased by 0.9% in the 2017 period compared to the 2016 period. The increase in same-hospital salaries, wages and benefits as a percentage of net operating revenues was primarily due to annual merit increases for certain of our employees, increased employee health benefits costs and the effect of lower volumes on operating leverage due to certain fixed staffing costs. Salaries, wages and benefits expense for the years ended December 31, 2017 and 2016 included stock-based compensation expense of $46 million and $58 million , respectively.

Supplies

Same-hospital supplies expense as a percentage of net operating revenues increased by 10 basis points to 17.3% in the year ended December 31, 2017 compared to the same period in 2016 . Supplies expense was impacted by growth in our higher acuity supply-intensive surgical services, partially offset by the benefits of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

Other Operating Expenses, Net

Same-hospital other operating expenses as a percentage of net operating revenues decreased by 120 basis points to 24.2% in the year ended December 31, 2017 compared to 25.4% in the same period in 2016 . Same-hospital other operating expenses decreased by $254 million , or 6.5% , and net operating revenues decreased by $281 million , or 1.8% , for the year ended December 31, 2017 compared to the year ended December 31, 2016. The changes in other operating expenses included:

- decreased expenses associated with our health plan businesses of $362 million due to the sale and wind-down of those businesses in 2017, which decreases were offset by decreased health plan revenues; and
- increased gains on sales of fixed assets of $24 million primarily due to the sale of our home health and hospice assets, partially offset by
- increased costs associated with funding indigent care services by hospitals we operated throughout both periods of $12 million , which costs were substantially offset by additional net patient revenues;

- increased medical fees of $54 million ; and
- increased malpractice expense of $28 million .

Same-hospital malpractice expense in the 2017 period included a favorable adjustment of approximately $3 million from the eight basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $4 million from the 16 basis point increase in the interest rate in the 2016 period.

Ambulatory Care Segment

Our Ambulatory Care segment is comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals, as well as Aspen's hospitals and clinics.

Year Ended December 31, 2017 Compared to the Year Ended December 31, 2016

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

	Years Ended December 31,	
Ambulatory Care Results of Operations	**2017**	**2016**
Net operating revenues	$ 1,940	$ 1,797
Equity in earnings of unconsolidated affiliates	$ 140	$ 122
Salaries, wages and benefits	$ 623	$ 594
Supplies	$ 398	$ 365
Other operating expenses, net	$ 360	$ 346

Our Ambulatory Care net operating revenues increased by $143 million , or 8.0% , for the year ended December 31, 2017 compared to the year ended December 31, 2016 . The growth in 2017 revenues was primarily driven by increases from acquisitions of $110 million .

Salaries, wages and benefits expense increased by $29 million , or 4.9% , for the year ended December 31, 2017 compared to the year ended December 31, 2016 . The 2017 increase was primarily driven by salaries, wages and benefits expense from acquisitions of $26 million .

Supplies expense increased by $33 million , or 9.0% , for the year ended December 31, 2017 compared to the year ended December 31, 2016 . The 2017 increase was primarily due to supplies expense from acquisitions of $27 million .

Other operating expenses increased by $14 million , or 4.0% , for the year ended December 31, 2017 compared to the year ended December 31, 2016 . The 2017 increase in other operating expenses was driven by other operating expenses from acquisitions of $18 million , partially offset by decreases in same-facility other operating expenses of $4 million .

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, 2017**
Net revenues	4.6%
Cases	0.6%
Net revenue per case	3.9%

Joint Ventures with Healthcare System Partners

USPI's business model is to jointly own its facilities with local physicians and not-for-profit healthcare systems. Accordingly, as of December 31, 2017 , the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities	Year Ended December 31, 2017
Facilities:	
With a healthcare system partner	193
Without a healthcare system partner	140
Total facilities operated	333
Change from December 31, 2016	
Acquisitions	9
De novo	3
Dispositions/Mergers	(2)
Total increase in number of facilities operated	10

During the year ended December 31, 2017 , we acquired controlling interests in a single-specialty gastroenterology surgery center in each of Texas and Arizona, a single-specialty ophthalmology surgery center in each of Florida and Kansas, a single-specialty orthopedics surgery center in Colorado, a multi-specialty surgery center in California and an imaging center in California. We paid cash totaling approximately $36 million for these acquisitions. All seven facilities are jointly owned with local physicians, and a healthcare system partner has an ownership interest in each of the Arizona, Colorado and Florida surgery centers. During the year ended December 31, 2017 , we acquired non-controlling interests in a surgical hospital in Texas and a multi-specialty surgery center in California. We paid cash totaling approximately $49 million for these ownership interests. Both facilities are jointly owned with local physicians and a healthcare system partner.

Conifer Segment

Conifer generated net operating revenues of approximately $1.597 billion and $1.571 billion during the years ended December 31, 2017 and 2016 , respectively, a portion of which was eliminated in consolidation as described in Note 22 to the Consolidated Financial Statements. The increase in revenues from third parties of $59 million , or 6.4% , for the year ended December 31, 2017 , which are not eliminated in consolidation, is primarily due to new clients. Conifer's contract with Tenet represented approximately 39% of the net operating revenues Conifer recognized in the year ended December 31, 2017 .

Salaries, wages and benefits expense for Conifer increased $3 million , or 0.3% , in the year ended December 31, 2017 compared to the year ended December 31, 2016 due to an increase in staffing as a result of the growth in Conifer's business primarily attributable to new clients.

Other operating expenses for Conifer increased $12 million , or 3.6% , in the year ended December 31, 2017 compared to the year ended December 31, 2016 due to the growth in Conifer's business primarily attributable to new clients.

Consolidated

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the year ended December 31, 2017 , we recorded impairment and restructuring charges and acquisition-related costs of $541 million , consisting of $402 million of impairment charges, $117 million of restructuring charges and $22 million of acquisition-related costs. Impairment charges consisted of $364 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for our Aspen, Philadelphia-area and certain of our Chicago-area facilities, $31 million for the impairment of two equity method investments and $7 million to write-down intangible assets. Of the total impairment charges recognized for the year ended December 31, 2017 , $337 million related to our Hospital Operations and other segment, $63 million related to our Ambulatory Care segment, and $2 million related to our Conifer segment. Restructuring charges consisted of $82 million of employee severance costs, $15 million of contract and lease termination fees, and $20 million of other restructuring costs. Acquisition-related costs consisted of $6 million of transaction costs and $16 million of acquisition integration charges.

During the year ended December 31, 2016 , we recorded impairment and restructuring charges and acquisition-related costs of $202 million . This amount included impairment charges of approximately $54 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software costs classified as other intangible assets, to their estimated fair values at four hospitals. Material adverse trends in our estimates of future undiscounted cash flows of the hospitals at that time indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of

the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $163 million at December 31, 2016 after recording the impairment charges. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract-related intangibles and capitalized software costs not associated with the hospitals described above. Of the total impairment charges recognized for the year ended December 31, 2016 , $76 million related to our Hospital Operations and other segment, $8 million related to our Ambulatory Care segment, and $3 million related to our Conifer segment. We also recorded $35 million of employee severance costs, $14 million of restructuring costs, $14 million of contract and lease termination fees, and $52 million in acquisition-related costs, which include $20 million of transaction costs and $32 million of acquisition integration costs.

Litigation and Investigation Costs

Litigation and investigation costs for the years ended December 31, 2017 and 2016 were $23 million and $293 million , respectively. For the year ended December 31, 2016 , $278 million was attributable to accruals for the previously disclosed civil qui tam litigation and parallel criminal investigation of the Company and certain of its subsidiaries.

Gains on Sales, Consolidation and Deconsolidation of Facilities

During the year ended December 31, 2017 , we recorded gains on sales, consolidation and deconsolidation of facilities of approximately $144 million , primarily comprised of an $111 million gain from the sale of our hospitals, physician practices and related assets in Houston, Texas and the surrounding area, $13 million from the sale of the membership of one of our health plans in Arizona, $10 million from the sale of our health plan membership in Texas, $3 million from the sale of our health plan in Michigan, and $9 million of gains related to the consolidation of certain businesses of USPI due to ownership changes.

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

Interest Expense

Interest expense for the year ended December 31, 2017 was $1.028 billion compared to $979 million for the year ended December 31, 2016 . These increases are attributable to additional senior notes issued in 2017, partially offset by the impact of the redemption of other senior notes since the 2016 period.

Income Tax Expense

During the year ended December 31, 2017 , we recorded income tax expense of $219 million in continuing operations on a pre-tax loss of $101 million , compared to income tax expense of $67 million on pre-tax income of $248 million during the year ended December 31, 2016 . The following table shows the reconciliation between the amount of recorded income tax expense (benefit) and the amount calculated at the statutory federal tax rate.

	Years Ended December 31,	
	2017	2016
Tax expense (benefit) at statutory federal rate of 35%	$ (35)	$ 87
State income taxes, net of federal income tax benefit	4	16
Expired state net operating losses, net of federal income tax benefit	28	35
Tax attributable to noncontrolling interests	(113)	(106)
Nondeductible goodwill	109	29
Nontaxable gains	—	(11)
Nondeductible litigation costs	—	37
Nondeductible acquisition costs	1	1
Nondeductible health insurance provider fee	—	2
Impact of decrease in federal tax rate on deferred taxes	246	—
Reversal of permanent reinvestment assumption for foreign subsidiary	(30)	—
Stock based compensation tax deficiencies	15	—
Changes in valuation allowance (including impact of decrease in federal tax rate)	—	(25)
Change in tax contingency reserves, including interest	(6)	(9)
Prior-year provision to return adjustments and other changes in deferred taxes	4	12
Other items	(4)	(1)
	$ 219	**$ 67**

As a result of the reduction in the corporate income tax rate from 35% to 21% under the Tax Act, we revalued our net deferred tax assets at December 31, 2017 , resulting in a reduction in the value of our net deferred tax assets of approximately $252 million . The reduction was recorded as additional income tax expense in the accompanying Consolidated Statement of Operations for the year ended December 31, 2017 . In the table above, approximately $6 million of the total $252 million increase in income tax expense is included in the net change in valuation allowance. Our revaluation of our deferred tax asset was subject to further revision based on our actual 2017 federal and state income tax filings.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests was $384 million for the year ended December 31, 2017 compared to $368 million for the year ended December 31, 2016 . Net income attributable to noncontrolling interests in the 2017 period was comprised of $29 million related to our Hospital Operations and other segment, $304 million related to our Ambulatory Care segment and $51 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $60 million was related to the minority interests in USPI, including $22 million related to the reduction of USPI's deferred tax liabilities as a result of the reduction in the corporate income tax rate from 35% to 21%.

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Our obligations to make future cash payments under contracts, such as debt and lease agreements, and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, are summarized in the table below, all as of December 31, 2018 :

		Years Ended December 31,					
	Total	2019	2020	2021	2022	2023	Later Years
				(In Millions)			
Long-term debt (1)	$ 18,227	$ 1,362	$ 3,455	$ 2,620	$ 4,021	$ 2,171	$ 4,598
Capital lease obligations (1)	559	192	106	64	44	27	126
Long-term non-cancelable operating leases	932	171	151	133	113	92	272
Standby letters of credit	95	95	—	—	—	—	—
Guarantees (2)	232	143	36	6	6	6	35
Asset retirement obligations	173	—	—	—	—	—	173
Academic affiliation agreements (3)	97	48	29	20	—	—	—
Tax liabilities	18	—	—	—	—	—	18
Defined benefit plan obligations	606	55	23	23	23	23	459
Information technology contract services	894	235	239	244	140	36	—
Purchase orders	300	300	—	—	—	—	—
Total (4)	**$ 22,133**	**$ 2,601**	**$ 4,039**	**$ 3,110**	**$ 4,347**	**$ 2,355**	**$ 5,681**

(1) Includes interest through maturity date/lease termination. Our 5.500% senior unsecured notes due 2019, which are included as 2019 obligations in this table, are not included in current portion of long-term debt in our Consolidated Balance Sheet at December 31, 2018 because of our intent and ability to refinance them on a long-term basis. See Note 24 to our Consolidated Financial Statements for additional information.

(2) Includes minimum revenue guarantees, primarily related to physicians under relocation agreements and physician groups that provide services at our hospitals, and operating lease guarantees.

(3) These agreements contain various rights and termination provisions.

(4) Professional liability and workers' compensation reserves, and our obligations under the Baylor Put/Call Agreement, as defined and described in Note 17 to our Consolidated Financial Statements, have been excluded from the table. At December 31, 2018 , the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were $216 million and $666 million , respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were $42 million and $145 million , respectively. Redeemable noncontrolling interests in USPI that are subject to the Baylor Put/Call Agreement totaled $186 million at December 31, 2018 .

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

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2018 :

- In December 2018 and November 2018, we purchased $22 million and $10 million , respectively, of aggregate principal amount of our 5.500% senior unsecured notes due 2019 for $22 million and $10 million , respectively.
- In August 2018, we purchased $38 million aggregate principal amount of our 6.875% senior unsecured notes due 2031 for $36 million , including $1 million in accrued and unpaid interest through the dates of purchase.
- In May 2018, we purchased $30 million aggregate principal amount of our 6.875% senior unsecured notes due 2031 for $28 million . In connection with the purchase, we recorded a loss from early extinguishment of debt of $1 million in the three months ended June 30, 2018, primarily related to the write-off of associated unamortized note discount and issuance costs, partially offset by the difference between the purchase price and the par value of the notes.
- In March 2018, we purchased $28 million aggregate principal amount of our 6.750% senior unsecured notes due 2023 and $22 million aggregate principal amount of our 7.000% senior unsecured notes due 2025 for $51 million , including $1 million in accrued and unpaid interest through the dates of purchase. In connection with these

purchases, we recorded a loss from early extinguishment of debt of $1 million in the three months ended March 31, 2018, primarily related to the write-off of associated unamortized issuance costs.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our cash and our operating results. We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash, including by means of the sale of underutilized or inefficient assets.

At December 31, 2018 , 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 5.63 x. 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 intend to manage this ratio by following our business plan, managing our cost structure, possible asset divestitures and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections in Part I of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements, introduction of new medical technologies, design and construction of new buildings, and various other capital improvements, as well as commitments to make capital expenditures in connection with acquisitions of businesses. Capital expenditures were $617 million , $707 million and $875 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2019 will total approximately $650 million to $700 million, including $135 million that was accrued as a liability at December 31, 2018 . We have been engaged in a series of legal challenges over the Certificate of Need ("CON") that the South Carolina Department of Health and Environmental Control ("SCDHEC") initially granted to us in 2005 to construct a new 100-bed acute care hospital in Fort Mill, South Carolina. Following a decision by the South Carolina Supreme Court in February 2019, the opponent to our CON now has one remaining right of appeal. If we ultimately prevail, we expect that we will finalize the design of the hospital soon after resolution and submit it to the SCDHEC for approval. Once construction begins, the hospital is expected to take up to two years to complete at a cost of approximately $170 million over the construction period.

Interest payments, net of capitalized interest, were $976 million , $939 million and $932 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. For the year ending December 31, 2019 , we expect annual interest payments to be approximately $980 million to $990 million.

Income tax payments, net of tax refunds, were $25 million , $56 million and $33 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. At December 31, 2018 , our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.0 billion pre-tax expiring in 2027 to 2034 , (2) general business credit carryforwards of approximately $26 million expiring in 2023 through 2038, and (3) state NOL carryforwards of approximately $3.1 billion expiring in 2019 through 2038 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $22 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 Internal Revenue Service ("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, 2014 remain subject to audit by the IRS.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2018 was primarily derived from net cash provided by operating activities, cash on hand and borrowings under our revolving credit facility. We had $411 million of cash and cash equivalents on hand at December 31, 2018 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $998 million based on our borrowing base calculation as of December 31, 2018 .

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

Net cash provided by operating activities was $1.049 billion for the year ended December 31, 2018 compared to $1.200 billion for the year ended December 31, 2017 . Key factors contributing to the change between the 2018 and 2017 periods include the following:

- An increase of $38 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;
- Decreased cash receipts of $31 million related to the California provider fee program;
- Additional interest payments of $37 million in the 2018 period primarily due to the six-month interest payment in January 2018 related to our 7.500% senior secured second lien notes due 2022, which were issued in December 2016, and changes in the timing of certain interest payments as a result of our refinancing transactions in 2017;
- Lower income tax payments of $31 million in the 2018 period;
- Increased cash flows from our health plan businesses of $101 million due to cash outflows in the 2017 period resulting from the sales and wind-down of these businesses in 2017, compared to negligible cash flows in the 2018 period; and
- The timing of other working capital items, including $129 million of additional payments for professional and general liability claims and expenses in the 2018 period.

Net cash used in investing activities was $115 million for the year ended December 31, 2018 compared to $21 million of net cash provided by investing activities for the year ended December 31, 2017 . The primary reason for the decrease was proceeds from sales of facilities and other assets of $543 million in the 2018 period when we completed the sale of our hospitals, physician practices and related assets in the Philadelphia area, the sale of MacNeal Hospital and other operations affiliated with the hospital in the Chicago area, the sale of Des Peres Hospital in St. Louis, the sale of nine Aspen facilities in the United Kingdom, and the sale of certain assets and the related liabilities of our health plan in California compared to proceeds from sales of facilities and other assets of $827 million in the 2017 period primarily attributable to the sale of our hospitals, physician practices and related assets in Houston, Texas. There was an increase in proceeds from sales of marketable securities, long-term investments and other assets of $163 million in the 2018 period compared to the 2017 period primarily due to the sales of our minority interests in four North Texas hospitals. Cash used for acquisitions of businesses and joint venture interests was $113 million in the 2018 period compared to $50 million in the 2017 period, primarily related to freestanding outpatient facilities acquired. Cash used for purchases of equity investments was $127 million in the 2018 period, compared to $68 million in the 2017 period, both of which were primarily due to acquisition activity from our Ambulatory Care segment. Capital expenditures were $617 million and $707 million in the years ended December 31, 2018 and 2017 , respectively.

Net cash used in financing activities was $1.134 billion for the year ended December 31, 2018 compared to $1.326 billion for the year ended December 31, 2017 . The 2018 amount included $647 million related to purchases of noncontrolling interests, primarily our purchase of an additional 15% ownership interest in USPI and to settle the adjustment to the price we paid in 2017 based on actual 2017 financial results of USPI, compared to $729 million related to purchases of noncontrolling interests in the 2017 period, when we increased our ownership interest in USPI from approximately 56.3% to 80%. The 2017 amount also included $62 million of cash paid for debt issuance costs due to significant debt refinancing activity in the 2017 period further described in Note 7 to our Consolidated Financial Statements. Additionally, the 2017 amount included our purchase of the land and improvements associated with our Palm Beach Gardens Medical Center, which we previously leased under a capital lease, by retiring the lease obligation for $44 million.

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

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

Credit Agreement. We have a senior secured revolving credit facility (as amended, the "Credit Agreement") that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion , with a $300 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of December 4, 2020, are guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and are secured by a first-priority lien on the accounts receivable owned by us and the subsidiary guarantors. At December 31, 2018 , we were in compliance with all covenants and conditions in our Credit Agreement. At December 31, 2018 , we had no cash borrowings outstanding under the Credit Agreement and we had $2 million of standby letters of credit outstanding. Based on our eligible receivables, $998 million was available for borrowing under the Credit Agreement at December 31, 2018 .

Letter of Credit Facility. We have a letter of credit facility (as amended, the "LC Facility") that provides for the issuance of standby and documentary letters of credit, from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The maturity date of the LC Facility is March 7, 2021. Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes. At December 31, 2018 , we were in compliance with all covenants and conditions in our LC Facility. At December 31, 2018 , we had $93 million of standby letters of credit outstanding under the LC Facility.

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

In 2018, we purchased $150 million aggregate principal amount of notes outstanding for $147 million, including $2 million in accrued and unpaid interest through the dates of purchase. For additional information regarding our long-term debt and capital lease obligations, see Note 7 to the accompanying Consolidated Financial Statements.

LIQUIDITY

From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time. We believe our existing debt agreements 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 and income tax payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that have caused, and in the future could cause, us to use our Credit Agreement as a source of liquidity. We believe that existing cash and cash equivalents on hand, availability under our Credit Agreement, anticipated future cash provided by operating activities, and our investments in marketable securities of our captive insurance companies classified as noncurrent investments on our balance sheet should be adequate to meet our current cash needs. These 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 other sections 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 period-end balance sheets. In addition, we do not have significant exposure to floating interest rates given that all of our current long-term indebtedness has fixed rates of interest.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the year ended December 31, 2016 include $2 million of net operating revenues and $7 million of operating loss generated from a hospital operated by us under an operating lease arrangement, which hospital was sold effective March 31, 2016. In accordance with GAAP, the applicable buildings and the future lease obligations under this arrangement were not recorded on our consolidated balance sheet.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $219 million of standby letters of credit outstanding and guarantees at December 31, 2018 .

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 23 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 to which we expect to be entitled 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 fee-for-service 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.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and/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, 2018 , a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million . Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage 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 self-pay patients and co-pays, co-insurance amounts and deductibles owed to us by patients with insurance at December 31, 2018 , a 10% decrease or increase in our self-pay collection rate, or approximately 2% , which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to patient accounts receivable of approximately $11 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 discounted 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, the timing of historical payments, and risk free discount rates used to determine the present value of projected payments. We consider the number of expected claims, average cost per claim and discount rate 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, 2018 , a 500 basis point increase in our frequency trend would increase the estimated reserves by $64 million , and a 500 basis point decrease in our frequency trend

would decrease the estimated reserves by $39 million . A 500 basis point increase in our severity trend would increase the estimated reserves by $118 million , and a 500 basis point decrease in our severity trend would decrease the estimated reserves by $80 million . Because our estimated reserves for future claim payments are discounted to present value, a change in our discount rate assumption could also have a significant impact on our estimated reserves. Our discount rate was 2.59% , 2.33% and 2.25% at December 31, 2018 , 2017 and 2016 , respectively. A 100 basis point increase or decrease in the discount rate would change the estimated reserves by $23 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, 2018 , 2017 and 2016 :

	December 31,		
	2018	2017	2016
Case reserves	$ 210	$ 194	$ 189
Incurred but not reported and loss development reserves	742	720	675
Total undiscounted reserves	**$ 952**	**$ 914**	**$ 864**

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 undiscounted reserves at December 31, 2018 and 2017 representing unsettled claims was approximately 93% and 98% , 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,		
	2018	2017	2016
Accrual for professional and general liability claims, beginning of the year	$ 854	$ 794	$ 755
Expense (income) related to: (1)			
Current year	226	243	228
Prior years	180	61	43
Expense (income) from discounting	(10)	(5)	(4)
Total incurred loss and loss expense	396	299	267
Paid claims and expenses related to:			
Current year	(3)	(2)	—
Prior years	(365)	(237)	(228)
Total paid claims and expenses	(368)	(239)	(228)
Accrual for professional and general liability claims, end of year	**$ 882**	**$ 854**	**$ 794**

(1) Total malpractice expense for continuing operations, including premiums for insured coverage and recoveries from third parties, was $388 million , $303 million and $281 million in the years ended December 31, 2018 , 2017 and 2016 , respectively.

IMPAIRMENT OF LONG-LIVED ASSETS

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment charge if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our

subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

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

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

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

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

- how the hospitals are operated in the future; and

- the nature of the ultimate disposition of the assets.

During the year ended December 31, 2018 , we recorded $77 million of impairment charges, including $40 million for the write-down of buildings and other long-lived assets to their estimated fair values at two hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $130 million at December 31, 2018 after recording the impairment charges. We also recorded $24 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities , $9 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $4 million of other impairment charges. Of the total impairment charges recognized for the year ended December 31, 2018 , $67 million related to our Hospital Operations and other segment, $9 million related to our Ambulatory Care segment, and $1 million related to our Conifer segment.

During the year ended December 31, 2017 , we recorded $402 million of impairment charges, consisting of $364 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen, our Philadelphia-area facilities and certain of our Chicago-area facilities, $31 million for the impairment of two equity method investments and $7 million to write-down intangible assets. Of the total impairment charges recognized for the year ended December 31, 2018 , $337 million related to our Hospital Operations and other segment, $63 million related to our Ambulatory Care segment, and $2 million related to our Conifer segment.

IMPAIRMENT OF GOODWILL

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

At December 31, 2018 , our continuing operations consisted of three reportable segments, Hospital Operations and other, 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, 2018. During the year ended December 31, 2017, we changed our annual quantitative goodwill impairment testing date from December 31 to October 1 of each year. The change in the goodwill impairment test date better aligns the impairment testing procedures with the timing of our long-term planning process, which is a significant input to the testing. Also, during January 2017, our Florida, Northeast and Southern regions and our Detroit market were combined to form our then Eastern region. Subsequent to this change, our Hospital Operations and other segment was comprised of our then Eastern, Texas and Western regions, which were our reporting units used to perform our goodwill impairment analysis. During October 2017, we further reorganized our business such that our regional management layer was eliminated. Due to this reorganization, our previous region reporting units for our Hospital Operations and other segment were combined into one reporting unit. The change in testing date and the change in reporting units did not delay, accelerate or avoid a goodwill impairment charge.

The allocated goodwill balance related to our Hospital Operations and other segment totals $2.980 billion . In our latest impairment analysis for the year ended December 31, 2018 , the estimated fair value of our Hospital Operations and other segment exceeded the carrying value of long-lived assets, including goodwill, by approximately 40%.

The allocated goodwill balance related to our Ambulatory Care segment totals $3.696 billion . In our latest impairment analysis for the year ended December 31, 2018 , the estimated fair value of our Ambulatory Care segment exceeded the carrying value of long-lived assets, including goodwill, by approximately 30%.

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

ACCOUNTING FOR INCOME TAXES

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

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

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

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;
- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;

- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

During the year ended December 31, 2018 , the valuation allowance increased by $76 million , including an increase of $89 million due to limitations on deductions of interest expense , a decrease of $9 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and a decrease of $4 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2018 was $148 million . During the year ended December 31, 2017 , we had no net change in the valuation allowance, but there was a decrease of $28 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, an increase of $6 million due to the decrease in the federal tax rate, and an increase of $22 million due to changes in expected realizability of deferred tax assets. The remaining balance in the valuation allowance at December 31, 2017 was $72 million .

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, 2018 . The fair values were determined based on quoted market prices for the same or similar instruments. The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table. Our 5.500% senior unsecured notes due 2019, which are included in the 2019 column in the following table, are not included in current portion of long-term debt in our Consolidated Balance Sheet at December 31, 2018 because of our intent and ability to refinance them on a long-term basis. See Note 24 to our Consolidated Financial Statements for additional information.

	Maturity Date, Years Ending December 31,							
	2019	2020	2021	2022	2023	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed-rate long-term debt	$ 650	$ 2,697	$ 1,958	$ 3,588	$ 1,894	$ 4,223	$ 15,010	$ 14,598
Average effective interest rates	5.7%	6.2%	4.7%	8.5%	7.3%	5.6%	6.5%	

At December 31, 2018 , we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as “special-purpose” or “variable-interest” entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements by us. 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, 2018 . 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, 2018 .

Tenet's internal control over financial reporting as of December 31, 2018 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, 2018 , and that firm's audit report on such Consolidated Financial Statements is also included herein.

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

/s/ RONALD A. RITTENMEYER	/s/ DANIEL J. CANCELMI
Ronald A. Rittenmeyer	Daniel J. Cancelmi
Executive Chairman and Chief Executive Officer	*Chief Financial Officer*
February 25, 2019	February 25, 2019

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, 2018 , 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, 2018 , 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, 2018 , of the Company and our report dated February 25, 2019 , 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 25, 2019

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, 2018 and 2017 , and 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, 2018 , 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, 2018 and 2017 , and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 , 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, 2018 , 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 25, 2019 , 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.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 25, 2019

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

CONSOLIDATED BALANCE SHEETS
Dollars in Millions

	December 31, 2018	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 411	$ 611
Accounts receivable (less allowance for doubtful accounts of $898 at December 31, 2017)	2,595	2,616
Inventories of supplies, at cost	305	289
Income tax receivable	21	5
Assets held for sale	107	1,017
Other current assets	1,197	1,035
Total current assets	**4,636**	**5,573**
Investments and other assets	1,456	1,543
Deferred income taxes	312	455
Property and equipment, at cost, less accumulated depreciation and amortization ($5,221 at December 31, 2018 and $4,739 at December 31, 2017)	6,993	7,030
Goodwill	7,281	7,018
Other intangible assets, at cost, less accumulated amortization ($1,013 at December 31, 2018 and $883 at December 31, 2017)	1,731	1,766
Total assets	**$ 22,409**	**$ 23,385**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 182	$ 146
Accounts payable	1,207	1,175
Accrued compensation and benefits	838	848
Professional and general liability reserves	216	200
Accrued interest payable	240	256
Liabilities held for sale	43	480
Other current liabilities	1,131	1,227
Total current liabilities	**3,857**	**4,332**
Long-term debt, net of current portion	14,644	14,791
Professional and general liability reserves	666	654
Defined benefit plan obligations	521	536
Deferred income taxes	36	36
Other long-term liabilities	578	631
Total liabilities	**20,302**	**20,980**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,420	1,866
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 150,897,143 shares issued at December 31, 2018 and 149,384,952 shares issued at December 31, 2017	7	7
Additional paid-in capital	4,747	4,859
Accumulated other comprehensive loss	(223)	(204)
Accumulated deficit	(2,236)	(2,390)
Common stock in treasury, at cost, 48,359,705 shares at December 31, 2018 and 48,413,169 shares at December 31, 2017	(2,414)	(2,419)
Total shareholders' deficit	**(119)**	**(147)**
Noncontrolling interests	**806**	**686**
Total equity	**687**	**539**
Total liabilities and equity	**$ 22,409**	**$ 23,385**

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2018	**2017**	**2016**
Net operating revenues:			
Net operating revenues before provision for doubtful accounts		$ 20,613	$ 21,070
Less: Provision for doubtful accounts		1,434	1,449
Net operating revenues	**$ 18,313**	**19,179**	**19,621**
Equity in earnings of unconsolidated affiliates	**150**	**144**	**131**
Operating expenses:			
Salaries, wages and benefits	8,634	9,274	9,328
Supplies	3,004	3,085	3,124
Other operating expenses, net	4,259	4,570	4,891
Electronic health record incentives	(3)	(9)	(32)
Depreciation and amortization	802	870	850
Impairment and restructuring charges, and acquisition-related costs	209	541	202
Litigation and investigation costs	38	23	293
Net gains on sales, consolidation and deconsolidation of facilities	(127)	(144)	(151)
Operating income	**1,647**	**1,113**	**1,247**
Interest expense	(1,004)	(1,028)	(979)
Other non-operating expense, net	(5)	(22)	(20)
Gain (loss) from early extinguishment of debt	1	(164)	—
Income (loss) from continuing operations, before income taxes	**639**	**(101)**	**248**
Income tax expense	(176)	(219)	(67)
Income (loss) from continuing operations, before discontinued operations	**463**	**(320)**	**181**
Discontinued operations:			
Income (loss) from operations	4	—	(6)
Income tax benefit (expense)	(1)	—	1
Income (loss) from discontinued operations	**3**	**—**	**(5)**
Net income (loss)	**466**	**(320)**	**176**
Less: Net income available to noncontrolling interests	355	384	368
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 111**	**$ (704)**	**$ (192)**
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders			
Income (loss) from continuing operations, net of tax	$ 108	$ (704)	$ (187)
Income (loss) from discontinued operations, net of tax	3	—	(5)
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 111**	**$ (704)**	**$ (192)**
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ 1.06	$ (7.00)	$ (1.88)
Discontinued operations	0.03	—	(0.05)
	$ 1.09	**$ (7.00)**	**$ (1.93)**
Diluted			
Continuing operations	$ 1.04	$ (7.00)	$ (1.88)
Discontinued operations	0.03	—	(0.05)
	$ 1.07	**$ (7.00)**	**$ (1.93)**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	102,110	100,592	99,321
Diluted	103,881	100,592	99,321

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2018	2017	2016
Net income (loss)	$ 466	$ (320)	$ 176
Other comprehensive income (loss):			
Adjustments for defined benefit plans	(29)	42	(73)
Amortization of net actuarial loss included in other non-operating expense, net	14	14	12
Unrealized gains (losses) on debt securities held as available-for-sale	—	6	2
Sale of foreign subsidiary	37	—	—
Foreign currency translation adjustments	(4)	15	(53)
Other comprehensive income (loss) before income taxes	**18**	**77**	**(112)**
Income tax benefit (expense) related to items of other comprehensive income (loss)	6	(23)	18
Total other comprehensive income (loss), net of tax	**24**	**54**	**(94)**
Comprehensive net income (loss)	**490**	**(266)**	**82**
Less: Comprehensive income attributable to noncontrolling interests	**355**	**384**	**368**
Comprehensive income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ 135**	**$ (650)**	**$ (286)**

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, 2015	**98,495**	**$ 7**	**$ 4,815**	**$ (164)**	**$ (1,550)**	**$ (2,417)**	**$ 267**	**$ 958**
Net income (loss)	—	—	—	—	(192)	—	138	(54)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(111)	(111)
Other comprehensive loss	—	—	—	(94)	—	—	—	(94)
Purchases (sales) of businesses and noncontrolling interests	—	—	(40)	—	—	—	146	106
Purchase accounting adjustments	—	—	—	—	—	—	225	225
Stock-based compensation expense, tax benefit and issuance of common stock	1,191	—	52	—	—	—	—	52
Balances at December 31, 2016	**99,686**	**7**	**4,827**	**(258)**	**(1,742)**	**(2,417)**	**665**	**1,082**
Net income (loss)	—	—	—	—	(704)	—	145	(559)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(123)	(123)
Other comprehensive income	—	—	—	54	—	—	—	54
Accretion of redeemable noncontrolling interests	—	—	(33)	—	—	—	—	(33)
Purchases (sales) of businesses and noncontrolling interests	—	—	4	—	—	—	(1)	3
Cumulative effect of accounting change	—	—	—	—	56	—	—	56
Stock-based compensation expense, tax benefit and issuance of common stock	1,286	—	61	—	—	(2)	—	59
Balances at December 31, 2017	**100,972**	**7**	**4,859**	**(204)**	**(2,390)**	**(2,419)**	**686**	**539**
Net income	—	—	—	—	111	—	165	276
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(148)	(148)
Other comprehensive income	—	—	—	24	—	—	—	24
Accretion of redeemable noncontrolling interests	—	—	(173)	—	—	—	—	(173)
Purchases (sales) of businesses and noncontrolling interests	—	—	3	—	—	—	103	106
Cumulative effect of accounting change	—	—	—	(43)	43	—	—	—
Stock-based compensation expense, tax benefit and issuance of common stock	1,565	—	58	—	—	5	—	63
Balances at December 31, 2018	**102,537**	**$ 7**	**$ 4,747**	**$ (223)**	**$ (2,236)**	**$ (2,414)**	**$ 806**	**$ 687**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2018	2017	2016
Net income (loss)	**$ 466**	**$ (320)**	**$ 176**
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	802	870	850
Provision for doubtful accounts	—	1,434	1,449
Deferred income tax expense	150	200	41
Stock-based compensation expense	46	59	68
Impairment and restructuring charges, and acquisition-related costs	209	541	202
Litigation and investigation costs	38	23	293
Net gains on sales, consolidation and deconsolidation of facilities	(127)	(144)	(151)
Loss (gain) from early extinguishment of debt	(1)	164	—
Equity in earnings of unconsolidated affiliates, net of distributions received	(12)	(18)	(13)
Amortization of debt discount and debt issuance costs	45	44	41
Pre-tax loss (income) from discontinued operations	(4)	—	6
Other items, net	(21)	(18)	(1)
Changes in cash from operating assets and liabilities:			
Accounts receivable	(134)	(1,448)	(1,604)
Inventories and other current assets	17	(35)	(83)
Income taxes	(3)	(38)	(8)
Accounts payable, accrued expenses and other current liabilities	(152)	(10)	(51)
Other long-term liabilities	(102)	26	40
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(163)**	**(125)**	**(691)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(5)**	**(5)**	**(6)**
Net cash provided by operating activities	**1,049**	**1,200**	**558**
Cash flows from investing activities:			
Purchases of property and equipment — continuing operations	(617)	(707)	(875)
Purchases of businesses or joint venture interests, net of cash acquired	(113)	(50)	(117)
Proceeds from sales of facilities and other assets	543	827	573
Proceeds from sales of marketable securities, long-term investments and other assets	199	36	62
Purchases of equity investments	(127)	(68)	(39)
Other long-term assets	15	(10)	(31)
Other items, net	(15)	(7)	(3)
Net cash provided by (used in) investing activities	**(115)**	**21**	**(430)**
Cash flows from financing activities:			
Repayments of borrowings under credit facility	(950)	(970)	(1,895)
Proceeds from borrowings under credit facility	950	970	1,895
Repayments of other borrowings	(312)	(4,139)	(154)
Proceeds from other borrowings	23	3,795	760
Debt issuance costs	—	(62)	(12)
Distributions paid to noncontrolling interests	(288)	(258)	(218)
Proceeds from sale of noncontrolling interests	20	31	22
Purchases of noncontrolling interests	(647)	(729)	(186)
Proceeds from exercise of stock options and employee stock purchase plan	16	7	4
Other items, net	54	29	16
Net cash provided by (used in) financing activities	**(1,134)**	**(1,326)**	**232**
Net increase (decrease) in cash and cash equivalents	(200)	(105)	360
Cash and cash equivalents at beginning of period	611	716	356
Cash and cash equivalents at end of period	**$ 411**	**$ 611**	**$ 716**
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (976)	$ (939)	$ (932)

Income tax payments, net	$ (25)	$ (56)	$ (33)

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. At December 31, 2018 , we operated 68 hospitals (three of which we have since divested), 23 surgical hospitals and approximately 475 outpatient centers through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI"). We hold noncontrolling interests in 111 of these facilities, which are recorded using the equity method of accounting. Our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities .

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

Basis of Presentation

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

Effective January 1, 2018, we adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09") using a modified retrospective method of application to all contracts existing on January 1, 2018. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. For our Hospital Operations and other and Ambulatory Care segments, the adoption of ASU 2014-09 resulted in changes to our presentation and disclosure of revenue primarily related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding material reduction in the amounts presented separately as provision for doubtful accounts. For the year ended December 31, 2018 , we recorded approximately $1.422 billion of implicit price concessions as a direct reduction of net operating revenues that would have been recorded as provision for doubtful accounts prior to the adoption of ASU 2014-09. At January 1, 2018, we reclassified $171 million of revenues related to patients who were still receiving inpatient care in our facilities at that date from accounts receivable, less allowance for doubtful accounts, to contract assets, which are included in other current assets in the accompanying Consolidated Balance Sheet at December 31, 2018 . The adoption of ASU 2014-09 also resulted in changes to our presentation and disclosure of customer contract assets and liabilities and the assessment of variable consideration under customer contracts, which are further discussed in Note 4.

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

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

Effective January 1, 2017, we adopted ASU 2016-09, "Compensation – Stock Compensation (Topic 718) Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-09"), which affects all entities that issue share-based payment awards to their employees. The guidance in ASU 2016-09 simplifies several aspects of the accounting for share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. Upon adoption of ASU 2016-09, we recorded previously unrecognized excess tax benefits of $56 million as a deferred tax asset and a cumulative effect adjustment to accumulated deficit as of January 1, 2017. Prospectively, all excess tax benefits and deficiencies will be recognized as income tax benefit or expense in our consolidated statement of operations when awards vest.

Also effective January 1, 2017, we early adopted ASU 2017-07, "Compensation – Retirement Benefits (Topic 715) Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost" ("ASU 2017-07"), which the FASB issued in March 2017. The amendments in ASU 2017-07 apply to all employers that offer to their employees defined benefit pension plans, other postretirement benefit plans, or other types of benefits accounted for under Topic 715 of the FASB Accounting Standards Codification ("ASC"). The guidance in ASU 2017-07 requires that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net periodic benefit cost are required to be presented in the statement of operations separately from the service cost component and outside a subtotal of income from operations. The line item or items used in the statement of operations to present the other components of net periodic benefit cost must be disclosed. The amendments in ASU 2017-07 must be applied retrospectively for the presentation of the service cost component and the other components of net periodic pension cost and net periodic postretirement benefit cost in the statement of operations. As a result of the adoption of ASU 2017-07, we reclassified $28 million of net periodic benefit cost from salaries, wages and benefits expense to other non-operating expense, net, in the accompanying Consolidated Statements of Operations for the year ended December 31, 2016, and $16 million and $31 million of other components of net periodic benefit cost are included in other non-operating expense, net, in the accompanying Consolidated Statement of Operations for the years ended December 31, 2018 and 2017 , respectively.

Certain prior-year amounts have also been reclassified to conform to current year presentation, primarily related to the format of disclosures in Note 14 that have been revised due to the adoption of ASU 2014-09 and the reclassification of previously held equity method investment changes due to acquisitions presented in Note 21.

Use of Estimates

The preparation of financial statements, in conformity with accounting principles generally accepted in the United States of America ("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.

Translation of Foreign Currencies

We divested European Surgical Partners Limited ("Aspen") in August 2018; prior to that time, Aspen's accounts were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities were translated using the current rate of exchange at the balance sheet date. Results of operations were translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates were accumulated in shareholders' equity until we divested Aspen.

Net Operating Revenues

ASU 2014-09 was issued to clarify the principles for recognizing revenue, to remove inconsistencies and weaknesses in revenue recognition requirements, and to provide a more robust framework for addressing revenue issues. Our adoption of ASU 2014-09 was accomplished using a modified retrospective method of application, and our accounting policies related to revenues were revised accordingly effective January 1, 2018, as discussed below.

We recognize net operating revenues in the period in which we satisfy our performance obligations under contracts by transferring our services to our customers. Net operating revenues are recognized in the amounts to which we expect to be entitled, which are the transaction prices allocated to the distinct services. Net operating revenues for our Hospital Operations and other 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 healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

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

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

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

We have provided implicit price concessions, primarily to uninsured patients and patients with co-pays, co-insurance and deductibles. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts we expect to collect based on our collection history with similar patients. Although

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

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Patient advocates from Conifer's Medical Eligibility Program screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs.

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

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

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

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

Electronic Health Record Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"), federal incentive payments are available to hospitals, physicians and certain other professionals when they adopt, implement or upgrade ("AIU") certified electronic health record ("EHR") technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use

criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved. During the years ended December 31, 2018 , 2017 and 2016 , certain of our hospitals and physicians satisfied the CMS AIU and/or meaningful use criteria. As a result, we recognized $3 million , $9 million and $32 million of Medicare and Medicaid EHR incentive payments as a reduction to expense in the accompanying Consolidated Statement of Operations for the years ended December 31, 2018 , 2017 and 2016 , respectively.

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 $411 million and $611 million at December 31, 2018 and 2017 , respectively. At December 31, 2018 and 2017 , our book overdrafts were $288 million and $311 million , respectively, which were classified as accounts payable.

At December 31, 2018 and 2017 , $177 million and $179 million , respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries, and $8 million and $30 million , respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our health plan-related businesses.

Also at December 31, 2018 and 2017 , we had $135 million and $117 million , respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $114 million and $79 million , respectively, were included in accounts payable.

During the years ended December 31, 2018 and 2017 , we recorded non-cancellable capital leases of $149 million and $162 million , respectively, primarily for equipment.

Investments in Debt and Equity Securities

Prior to the adoption of ASU 2016-01 on January 1, 2018, we classified investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2017, we had no significant investments in securities classified as either held-to-maturity or trading. We carried securities classified as available-for-sale at fair value. We reported their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determined that a loss was other-than-temporary, at which point we would record a loss in our consolidated statements of operations. We included realized gains or losses in our consolidated statements of operations based on the specific identification method.

Subsequent to the adoption of ASU 2016-01 on January 1, 2018, we classify investments in debt securities as either available-for-sale, held-to-maturity or as part of a trading portfolio, but these classifications are no longer applicable to equity securities. At December 31, 2018 , 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. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Investments in Unconsolidated Affiliates

We control 227 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 (110 of 337 at December 31, 2018), as well as additional companies in which our Hospital Operations and other 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. Summarized financial information for these equity method investees is included in the following table; among the equity method investees are four North Texas hospitals in which we held minority interests and that were operated by our Hospital Operations and other segment through the divestiture of these investments effective March 1, 2018. We recorded a gain of $11 million in the year ended December 31, 2018 due to the sales of our minority interest in these hospitals. For investments acquired during the reported periods, amounts reflect 100% of the investee’s results beginning on the date of our acquisition of the investment.

	December 31, 2018	December 31, 2017	December 31, 2016
Current assets	$ 842	$ 805	$ 943
Noncurrent assets	$ 662	$ 1,223	$ 991
Current liabilities	$ (313)	$ (354)	$ (320)
Noncurrent liabilities	$ (430)	$ (389)	$ (345)
Noncontrolling interests	$ (530)	$ (490)	$ (494)

	Years Ended December 31,		
	2018	2017	2016
Net operating revenues	$ 2,469	$ 2,907	$ 2,823
Net income	$ 599	$ 558	$ 573
Net income attributable to the investees	$ 372	$ 363	$ 343

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 $70 million of the total $150 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2018 , $69 million of the total $144 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2017 and $61 million of the total $131 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2016 .

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. We record capital leases at the beginning of the lease term as assets and liabilities. The value recorded is the lower of either the present value of the minimum lease payments or the fair value of the asset. Such assets, including improvements, are generally amortized over the shorter of either the lease term or their estimated useful life. Interest costs related to construction projects are capitalized. In the years ended December 31, 2018 , 2017 and 2016 , capitalized interest was $7 million , $15 million and $22 million , respectively.

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

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

Goodwill and Other Intangible Assets

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

Other intangible assets primarily 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 for incurred but not reported claims, is updated each quarter based on a model of projected payments using case-specific facts and circumstances and our historical loss reporting, development and settlement patterns and is discounted to its net present value using a risk-free discount rate of 2.59% at December 31, 2018 and 2.33% at December 31, 2017 . 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 and other segment generated 80% , 82% and 83% of our net operating revenues net of implicit price concessions and provision for doubtful accounts in the years ended December 31, 2018 , 2017 and 2016 , respectively. At December 31, 2018 , each of our markets related to our general hospitals reported directly to our president of hospital operations. Major decisions, including capital resource allocations, are made at the consolidated level, not at the market or hospital level.

Our Hospital Operations and other segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 5 , certain of our facilities were classified as held for sale in the accompanying Consolidated Balance Sheet at December 31, 2018 . Our Ambulatory Care

segment is comprised of the operations of USPI and included nine Aspen facilities in the United Kingdom until their divestiture effective August 17, 2018. Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities . 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. EQUITY

Noncontrolling Interests

Our noncontrolling interests balances at December 31, 2018 and 2017 in the accompanying Consolidated Statements of Changes in Equity were comprised of $112 million and $64 million , respectively, from our Hospital Operations and other segment, and $694 million and $622 million , respectively, from our Ambulatory Care segment. Our net income attributable to noncontrolling interests for the years ended December 31, 2018 , 2017 and 2016 were comprised of $8 million , $11 million and $11 million , respectively, from our Hospital Operations and other segment, and $157 million , $134 million and $127 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, 2018	December 31, 2017
Continuing operations:		
Patient accounts receivable	$ 2,427	$ 3,376
Allowance for doubtful accounts	—	(898)
Estimated future recoveries	148	132
Net cost reports and settlements payable and valuation allowances	18	4
	2,593	2,614
Discontinued operations	2	2
Accounts receivable, net	**$ 2,595**	**$ 2,616**

Accounts that are pursued for collection through Conifer's business offices are maintained on our hospitals' books and reflected in patient accounts receivable. For patient accounts receivable resulting from revenue recognized prior to January 1, 2018, an allowance for doubtful accounts was established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimated this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. At December 31, 2017 , our allowance for doubtful accounts was 26.6% of our patient accounts receivable. Under the provisions of ASC 2014-09, which we adopted effective January 1, 2018, when we have an unconditional right to payment, subject only to the passage of time, the right is treated as a receivable. Patient accounts receivable, including billed accounts and unbilled accounts for which we have the unconditional right to payment, and 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. For patient accounts receivable subsequent to our adoption of ASU 2014-09 on January 1, 2018, the estimated uncollectable amounts are generally considered implicit price concessions that are a direct reduction to patient accounts receivable rather than allowance for doubtful accounts.

Accounts assigned to Conifer are written off and excluded from patient accounts receivable; however, an estimate of future recoveries from all accounts at Conifer is determined based on historical experience and recorded on our hospitals' books as a component of accounts receivable in the accompanying Consolidated Balance Sheets.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination

of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The table below shows our estimated costs of caring for our self-pay patients and charity care patients, as well as revenues attributable to Medicaid DSH and other supplemental revenues we recognized in the years ended December 31, 2018 , 2017 and 2016 .

	Years Ended December 31,		
	2018	2017	2016
Estimated costs for:			
Self-pay patients	$ 640	$ 648	$ 609
Charity care patients	124	121	138
Total	$ 764	$ 769	$ 747
Medicaid DSH and other supplemental revenues	$ 847	$ 864	$ 906

We had $278 million and $231 million of receivables recorded in other current assets and investments and other assets, respectively, and $100 million and $42 million of payables recorded in other current liabilities and other long-term liabilities, respectively, in the accompanying Consolidated Balance Sheet at December 31, 2018 related to California's provider fee program. We had $312 million and $266 million of receivables recorded in other current assets and investments and other assets, respectively, and $159 million and $49 million of payables recorded in other current liabilities and other long-term liabilities, respectively, in the accompanying Consolidated Balance Sheet at December 31, 2017 related to California's provider fee program.

NOTE 4. CONTRACT BALANCES

Hospital Operations and Other Segment

Under the provisions of ASU 2014-09, which we adopted effective January 1, 2018, 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 and other segment, our contract assets consist primarily of 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 and other segment's contract assets are included in other current assets in the accompanying Consolidated Balance Sheet at December 31, 2018. The opening and closing balances of contract assets for our Hospital Operations and other segment are as follows:

	2018	2017
January 1,	$ 171	$ —
December 31,	169	—
Increase/(decrease)	**$ (2)**	**$ —**

The increase in the contract asset balances from the year ended December 31, 2018 compared to the year ended December 31, 2017 is due to the implementation of ASU 2014-09 effective January 1, 2018 using a modified retrospective method of application. Prior to January 1, 2018, amounts related to services provided to patients for which we had not billed were included in accounts receivable, less allowance for doubtful accounts, in our consolidated balance sheets. Approximately 89% of our Hospital Operations and other segment's contract assets meet the conditions for unconditional right to payment and are reclassified to patient receivables within 90 days.

Conifer Segment

Conifer enters into contracts with customers to sell revenue cycle management and other services, such as value-based care, consulting and project services. The payment terms and conditions in our customer contracts vary. In some cases, customers are invoiced in advance and (for other than fixed-price fee arrangements) a true-up to the actual fee is included on a subsequent invoice. In other cases, payment is due in arrears. In addition, some contracts contain performance incentives, penalties and other forms of variable consideration. When the timing of Conifer's delivery of services is different from the timing of payments made by the customers, Conifer recognizes either unbilled revenue (performance precedes contractual right

to invoice the customer) or deferred revenue (customer payment precedes Conifer service performance). In the following table, customers that prepay prior to obtaining control/benefit of the service are represented by deferred contract revenue until the performance obligations are satisfied. Unbilled revenue represents arrangements in which Conifer has provided services to and the customer has obtained control/benefit of services prior to the contractual invoice date. Contracts with payment in arrears are recognized as receivables in the month the service is performed.

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

	Receivables	Contract Asset-Unbilled Revenue	Contract Liability-Current Deferred Revenue	Contract Liability-Long-Term Deferred Revenue
January 1, 2018	$ 89	$ 10	$ 80	$ 21
December 31, 2018	42	11	61	20
Increase/(decrease)	**$ (47)**	**$ 1**	**$ (19)**	**$ (1)**
January 1, 2017	$ 67	$ 8	$ 76	$ 26
December 31, 2017	89	10	80	21
Increase/(decrease)	**$ 22**	**$ 2**	**$ 4**	**$ (5)**

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

The amount of revenue Conifer recognized in the years ended December 31, 2018 and 2017 that was included in the opening current deferred revenue liability was $72 million and $73 million , respectively. This revenue consists primarily of prepayments for those customers who are billed in advance, changes in estimates related to metric-based services, and up-front integration services that are recognized over the services period.

Contract Costs

We have elected to apply the practical expedient provided by ASC 340-40-25-4 and expense as incurred the incremental customer contract acquisition costs for contracts in which the amortization period of the asset that we otherwise would have recognized is one year or less. However, incremental costs incurred to obtain and fulfill customer contracts for which the amortization period of the asset that we otherwise would have recognized is longer than one year, which consist primarily of Conifer deferred contract setup costs, are capitalized and amortized on a straight-line basis over the lesser of their estimated useful lives or the term of the related contract. During the years ended December 31, 2018 , 2017 and 2016 , we recognized amortization expense of $11 million , $10 million and 7 million , respectively. At December 31, 2018 and 2017 , the unamortized customer contract costs were $28 million and $35 million , respectively, and are presented as part of investments and other assets in the accompanying Consolidated Balance Sheets.

NOTE 5. ASSETS AND LIABILITIES HELD FOR SALE

In the three months ended December 31, 2017, three of our hospitals in the Chicago area, as well as other operations affiliated with the hospitals, met the criteria to be classified as held for sale. As a result, we have classified these assets totaling $107 million as "assets held for sale" in current assets and the related liabilities of $43 million as "liabilities held for sale" in current liabilities in the accompanying Consolidated Balance Sheet at December 31, 2018 . These assets and liabilities, which were in our Hospital Operations and other segment until their divestiture on January 28, 2019, were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. We recorded impairment charges of $24 million and $73 million in the years ended December 31, 2018 and December 31, 2017 , respectively, for the write-down of the assets held for sale to their estimated fair value, less estimated costs to sell, as a result of the planned divestiture of these assets.

Assets and liabilities classified as held for sale at December 31, 2018 were comprised of the following:

Accounts receivable	$	54
Other current assets		13
Investments and other long-term assets		1
Property and equipment		39
Current liabilities		(36)
Long-term liabilities		(7)
Net assets held for sale	**$**	**64**

In the three months ended December 31, 2018, we completed the sale of certain assets and the related liabilities of our health plan in California; these assets and the related liabilities were classified as held for sale in the three months ended December 31, 2017. As a result of this transaction, we recorded a gain on sale of $36 million and received net pre-tax cash proceeds of $53 million in the year ended December 31, 2018 .

In the three months ended September 30, 2018, we completed the sale of our nine Aspen facilities in the United Kingdom for net pre-tax cash proceeds of approximately $15 million ; these assets met the criteria to be classified as held for sale in the three months ended September 30, 2017. We recorded impairment charges related to this transaction of $9 million and $59 million in the years ended December 31, 2018 and 2017, respectively, for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell.

In the three months ended June 30, 2018, we completed the sale of our hospital, physician practices and other hospital-affiliated operations in St. Louis, Missouri; these assets met the criteria to be classified as held for sale in the three months ended December 31, 2017. As a result of this transaction, we recorded a gain on sale of $12 million and received net pre-tax cash proceeds of $54 million in the three months ended June 30, 2018.

In the three months ended March 31, 2018, we completed the sale of MacNeal Hospital, which is located in a suburb of Chicago, and other operations affiliated with the hospital; these assets met the criteria to be classified as held for sale in the three months ended September 30, 2017. As a result of this transaction, we recorded a gain on sale of $90 million and received net pre-tax cash proceeds of $241 million after post-closing adjustments in the year ended December 31, 2018 .

Also in the three months ended March 31, 2018, we completed the sale of our hospitals, physician practices and related assets in Philadelphia, Pennsylvania and the surrounding area; these assets met the criteria to be classified as held for sale in the three months ended September 30, 2017. As a result of the transaction, we recorded a loss on sale of $21 million and received net pre-tax proceeds of $132 million in cash after post-closing adjustments and a secured promissory note for $17.5 million in the year ended December 31, 2018. We recorded impairment charges related to this transaction of $232 million in the year ended December 31, 2017 for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell.

The real estate related to Abrazo Maryvale Hospital in Arizona, which we closed in December 2017, was divested in the three months ended March 31, 2018, resulting in net pre-tax proceeds of $7 million . The real estate was classified as held for sale in the three months ended December 31, 2017.

In the three months ended September 30, 2017, we completed the sale of our hospitals, physician practices and related assets in Houston, Texas and the surrounding area for net proceeds of approximately $750 million ; these assets met the criteria to be classified as held for sale in the three months ended June 30, 2017. We recognized a gain on sale related to this transaction of $111 million in the year ended December 31, 2017. We recorded a loss on sale of $10 million for post-closing adjustments related to this transaction in the year ended December 31, 2018.

The following table provides information on significant components of our business that have been recently disposed of or are classified as held for sale at December 31, 2018:

	Years Ended December 31,		
	2018	2017	2016
Significant disposals:			
Income (loss) from continuing operations, before income taxes			
Houston (includes a $111 million gain on sale in the 2017 period)	$ (10)	$ 133	$ 67
Philadelphia (includes $232 million of impairment charges in the 2017 period)	$ (29)	$ (255)	$ (75)
MacNeal (includes a $90 million gain on sale in the 2018 period)	93	27	29
Aspen (includes $59 million of impairment charges in the 2017 period)	$ (6)	$ (68)	$ (16)
Total	48	(163)	5
Significant planned divestitures classified as held for sale:			
Loss from continuing operations, before income taxes			
Chicago area (includes $24 million of impairment charges in the 2018 period and $73 million in the 2017 period)	(41)	(82)	(1)
Total	$ (41)	$ (82)	$ (1)

During the year ended December 31, 2017, we completed the sales of certain of our health plan businesses (or the membership thereof) in Michigan, Arizona and Texas at transaction prices of $20 million , $13 million and $12 million , respectively, and recognized gains on the sales of $3 million , $13 million and $10 million , respectively. These assets met the criteria to be classified as held for sale in the three months ended September 30, 2016.

During the year ended December 31, 2016, we completed the sale of our hospitals, physician practices and related assets in Georgia at a transaction price of approximately $575 million and recognized a gain on sale of $113 million . These assets met the criteria to be classified as held for sale in the three months ended June 30, 2015.

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

We recognized impairment charges on long-lived assets in 2018 , 2017 and 2016 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in healthcare industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

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

At December 31, 2018 , our continuing operations consisted of three reportable segments, Hospital Operations and other, 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, 2018. During the year ended December 31, 2017, we changed our annual quantitative goodwill impairment testing date from December 31 to October 1 of each year. The change in the goodwill impairment test date better aligns the impairment testing procedures with the timing of our long-term planning process, which is a significant input to the testing. Also, during January 2017, our Florida, Northeast and Southern regions and our Detroit market were combined to form our then Eastern region. Subsequent to this change, our Hospital Operations and other segment was comprised of our then Eastern, Texas and Western regions, which were our reporting units used to perform our goodwill impairment analysis. During October 2017, we further reorganized our business such that our regional management layer was eliminated. Due to this reorganization, our previous region reporting units for our Hospital Operations

and other segment were combined into one reporting unit. The change in testing date and the change in reporting units did not delay, accelerate or avoid a goodwill impairment charge.

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

Year Ended December 31, 2018

During the year ended December 31, 2018 , we recorded impairment and restructuring charges and acquisition-related costs of $209 million , consisting of $77 million of impairment charges , $115 million of restructuring charges and $17 million of acquisition-related costs. Impairment charges included $40 million for the write-down of buildings and other long-lived assets to their estimated fair values at two hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $130 million at December 31, 2018 after recording the impairment charges. We also recorded $24 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities , $9 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $4 million of other impairment charges. Of the total impairment charges recognized for the year ended December 31, 2018 , $67 million related to our Hospital Operations and other segment, $9 million related to our Ambulatory Care segment, and $1 million related to our Conifer segment. Restructuring charges consisted of $68 million of employee severance costs , $17 million of contract and lease termination fees , and $30 million of other restructuring costs . Acquisition-related costs consisted of $10 million of transaction costs and $7 million of acquisition integration charges .

Year Ended December 31, 2017

During the year ended December 31, 2017 , we recorded impairment and restructuring charges and acquisition-related costs of $541 million , consisting of $402 million of impairment charges, $117 million of restructuring charges and $22 million of acquisition-related costs. Impairment charges consisted of $364 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen, our Philadelphia-area facilities and certain of our Chicago-area facilities, $31 million for the impairment of two equity method investments and $7 million to write-down intangible assets. Of the total impairment charges recognized for the year ended December 31, 2017 , $337 million related to our Hospital Operations and other segment, $63 million related to our Ambulatory Care segment, and $2 million related to our Conifer segment. Restructuring charges consisted of $82 million of employee severance costs, $15 million of contract and lease termination fees, and $20 million of other restructuring costs. Acquisition-related costs consisted of $6 million of transaction costs and $16 million of acquisition integration charges.

Year Ended December 31, 2016

During the year ended December 31, 2016 , we recorded impairment and restructuring charges and acquisition-related costs of $202 million . This amount included impairment charges of $54 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software costs classified as other intangible assets, to their estimated fair values at four hospitals. Material adverse trends in our estimates of future undiscounted cash flows of the hospitals at that time indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $163 million at December 31, 2016 after recording the impairment charges. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract-related intangibles and

capitalized software costs not associated with the hospitals described above. Of the total impairment charges recognized for the year ended December 31, 2016 , $76 million related to our Hospital Operations and other segment, $8 million related to our Ambulatory Care segment, and $3 million related to our Conifer segment. We also recorded $35 million of employee severance costs, $14 million of restructuring costs, $14 million of contract and lease termination fees, and $52 million in acquisition-related costs, which include $20 million of transaction costs and $32 million of acquisition integration costs.

NOTE 7. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of December 31, 2018 and 2017 :

	December 31, 2018	December 31, 2017
Senior unsecured notes:		
5.500% due 2019	$ 468	$ 500
6.750% due 2020	300	300
8.125% due 2022	2,800	2,800
6.750% due 2023	1,872	1,900
7.000% due 2025	478	500
6.875% due 2031	362	430
Senior secured first lien notes:		
4.750% due 2020	500	500
6.000% due 2020	1,800	1,800
4.500% due 2021	850	850
4.375% due 2021	1,050	1,050
4.625% due 2024	1,870	1,870
Senior secured second lien notes:		
7.500% due 2022	750	750
5.125% due 2025	1,410	1,410
Capital leases	425	431
Mortgage notes	75	77
Unamortized issue costs, note discounts and premiums	(184)	(231)
Total long-term debt	**14,826**	**14,937**
Less current portion	182	146
Long-term debt, net of current portion	**$ 14,644**	**$ 14,791**

Credit Agreement

We have a senior secured revolving credit facility (as amended, the "Credit Agreement") that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion , with a $300 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of December 4, 2020, are guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and are secured by a first-priority lien on the accounts receivable owned by us and the subsidiary guarantors. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 0.25% to 0.75% per annum or the London Interbank Offered Rate ("LIBOR") 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 accounts receivable, including self-pay accounts . At December 31, 2018 , we were in compliance with all covenants and conditions in our Credit Agreement. At December 31, 2018 , we had no cash borrowings outstanding under the Credit Agreement and we had $2 million of standby letters of credit outstanding. Based on our eligible receivables, $998 million was available for borrowing under the Credit Agreement at December 31, 2018 . Our Credit Agreement contains provisions that limit the payment of cash dividends on our common stock if we do not meet certain financial ratios.

Letter of Credit Facility

We have a letter of credit facility (as amended, the "LC Facility") that provides for the issuance of standby and documentary letters of credit, from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The maturity date of the LC Facility is March 7, 2021. Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes.

Drawings under any letter of credit issued under the LC Facility that we have not reimbursed within three business days after notice thereof accrue interest at a base rate plus a margin equal to 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, 2018 , we were in compliance with all covenants and conditions in our LC Facility. At December 31, 2018 , we had $93 million of standby letters of credit outstanding under the LC Facility.

Senior Secured Notes and Senior Unsecured Notes

In December 2018 and November 2018, we purchased $22 million and $10 million , respectively, of aggregate principal amount of our 5.500% senior unsecured notes due 2019 for $22 million and $10 million , respectively.

In August 2018, we purchased $38 million aggregate principal amount of our 6.875% senior unsecured notes due 2031 for $36 million , including $1 million in accrued and unpaid interest through the dates of purchase.

In May 2018, we purchased $30 million aggregate principal amount of our 6.875% senior unsecured notes due 2031 for $28 million . In connection with the purchase, we recorded a loss from early extinguishment of debt of $1 million in the three months ended June 30, 2018, primarily related to the write-off of associated unamortized note discount and issuance costs, partially offset by the difference between the purchase price and the par value of the notes.

In March 2018, we purchased $28 million aggregate principal amount of our 6.750% senior unsecured notes due 2023 and $22 million aggregate principal amount of our 7.000% senior unsecured notes due 2025 for $51 million , including $1 million in accrued and unpaid interest through the dates of purchase. In connection with these purchases, we recorded a loss from early extinguishment of debt of $1 million in the three months ended March 31, 2018, primarily related to the write-off of associated unamortized issuance costs.

On June 14, 2017, we sold $830 million aggregate principal amount of our 4.625% senior secured first lien notes, which will mature on July 15, 2024 (the “2024 Secured First Lien Notes”) . We will pay interest on the 2024 Secured First Lien Notes semi-annually in arrears on January 15 and July 15 of each year, which payments commenced on January 15, 2018. The proceeds from the sale of the 2024 Secured First Lien Notes were used, after payment of fees and expenses, together with cash on hand, to deposit with the trustee an amount sufficient to fund the redemption of all $900 million in aggregate principal amount of our outstanding floating rate senior secured notes due 2020 (the “2020 Floating Rate Notes”) on July 14, 2017, thereby fully discharging the 2020 Floating Rate Notes as of June 14, 2017. In connection with the redemption, we recorded a loss from early extinguishment of debt of $26 million in the three months ended June 30, 2017, primarily related to the difference between the redemption price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs.

Also on June 14, 2017, THC Escrow Corporation III (“ Escrow Corp. ”), a Delaware corporation established for the purpose of issuing the securities referred to in this paragraph, issued $1.040 billion in aggregate principal amount of 4.625% senior secured first lien notes due 2024 (the “Escrow Secured First Lien Notes”) , $1.410 billion in aggregate principal amount of 5.125% senior secured second lien notes due 2025 (the “Escrow Secured Second Lien Notes”) and $500 million in aggregate principal amount of 7.000% senior unsecured notes due 2025 (the “Escrow Unsecured Notes”) .

On July 14, 2017, we (i) assumed Escrow Corp.’s obligations with respect to the Escrow Secured Second Lien Notes and (ii) effected a mandatory exchange of all outstanding Escrow Secured First Lien Notes for a like principal amount of our newly issued 2024 Secured First Lien Notes. The proceeds from the sale of the Escrow Secured Second Lien Notes and Escrow Secured First Lien Notes were released from escrow on July 14, 2017 and were used, after payment of fees and expenses, to finance our redemption on July 14, 2017 of $1.041 billion aggregate principal amount of our outstanding 6.250% senior secured notes due 2018 and $1.100 billion aggregate principal amount of our outstanding 5.000% senior unsecured notes due 2019.

On August 1, 2017, we assumed Escrow Corp.’s obligations with respect to the Escrow Unsecured Notes. The proceeds from the sale of the Escrow Unsecured Notes were released from escrow on August 1, 2017 and were used, after payment of fees and expenses, to finance our redemption on August 1, 2017 of $500 million aggregate principal amount of our outstanding 8.000% senior unsecured notes due 2020.

On September 11, 2017, we redeemed the remaining $250 million aggregate principal amount of our outstanding 8.000% senior unsecured notes due 2020 using cash on hand.

As a result of the redemption activities in the three months ended September 30, 2017 discussed above, we recorded a loss from early extinguishment of debt of $138 million in the period, primarily related to the difference between the redemption price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs.

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 $100 million , as well as limits on debt, asset sales and prepayments of senior 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 $100 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 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; and indentures governing certain of our senior secured first lien notes further provide that the aggregate amount of all such debt

secured by a lien on par to the lien securing the senior secured first lien notes may not exceed the amount that would cause the secured debt ratio to exceed 3.0 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 and minimum operating lease payments as of December 31, 2018 are as follows:

		Years Ending December 31,					
	Total	2019	2020	2021	2022	2023	Later Years
Long-term debt, including capital lease obligations	$ 15,010	$ 182	$ 2,697	$ 1,958	$ 3,588	$ 1,894	$ 4,691
Long-term non-cancelable operating leases	$ 932	$ 171	$ 151	$ 133	$ 113	$ 92	$ 272

Rental expense under operating leases, including short-term leases, was $326 million , $340 million and $335 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. Included in rental expense for each of these periods was sublease income of $11 million , $14 million and $13 million , respectively, which was recorded as a reduction of rental expense.

NOTE 8. 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, 2018 , 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 $166 million . We had a total liability of $123 million recorded for these guarantees included in other current liabilities at December 31, 2018 .

At December 31, 2018 , 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 $24 million . Of the total, $8 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Consolidated Balance Sheet at December 31, 2018 .

NOTE 9. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

In recent years, we have granted both options and restricted stock units to certain of our employees and directors pursuant to our 2008 Stock Incentive Plan, as amended. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock in the future. Typically, options and time-based restricted stock units vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have different vesting terms. In addition, we grant performance-based options and performance-based restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe. At December 31, 2018 , assuming outstanding

performance-based restricted stock units and options for which performance has not yet been determined will achieve target performance, approximately 5.3 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other equity incentive awards, including restricted stock units (4.1 million shares remain available if we assume maximum performance for outstanding performance restricted stock units and options for which performance has not yet been determined).

The accompanying Consolidated Statements of Operations for the years ended December 31, 2018 , 2017 and 2016 include $46 million , $59 million and $60 million , respectively, of pre-tax compensation costs related to our stock-based compensation arrangements. The table below shows certain stock option and restricted stock unit grants and other awards that comprise the stock-based compensation expense recorded in the year ended December 31, 2018 . 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, 2018
	(In Thousands)			(In Millions)
Stock Options:				
February 28, 2018	593	$ 20.60	$ 8.83	$ 2
September 29, 2017	409	$ 16.43	$ 5.63	2
March 1, 2017	877	$ 18.99	$ 8.52	1
Restricted Stock Units:				
June 28, 2018	51		$ 34.61	1
May 4, 2018	54		$ 23.53	1
March 29, 2018	293		$ 24.25	3
February 28, 2018	272		$ 20.60	2
March 1, 2017	404		$ 18.99	2
June 30, 2016	113		$ 27.64	1
May 31, 2016	54		$ 28.94	1
March 10, 2016	566		$ 25.50	3
February 25, 2015	1,374		$ 45.63	1
August 25, 2014	460		$ 59.90	4
Other grants				4
USPI Management Equity Plan				18
				$ 46

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

Stock Options

The following table summarizes stock option activity during the years ended December 31, 2018 , 2017 and 2016 :

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value	Weighted Average Remaining Life
			(In Millions)	
Outstanding at December 31, 2015	1,606,842	$ 22.87		
Granted	—	—		
Exercised	(111,715)	17.88		
Forfeited/Expired	(59,206)	18.68		
Outstanding at December 31, 2016	1,435,921	$ 22.87		
Granted	1,396,307	18.24		
Exercised	(20,400)	4.56		
Forfeited/Expired	(247,006)	24.37		
Outstanding at December 31, 2017	2,564,822	$ 20.35		
Granted	635,196	21.33		
Exercised	(619,849)	18.19		
Forfeited/Expired	(317,426)	35.30		
Outstanding at December 31, 2018	**2,262,743**	**$ 19.12**	**$ 1**	**6.7 years**
Vested and expected to vest at December 31, 2018	**2,262,743**	**$ 19.12**	**$ 1**	**6.7 years**
Exercisable at December 31, 2018	**767,037**	**$ 17.47**	**$ 1**	**3.2 years**

There were 619,849 stock options exercised during the year ended December 31, 2018 with an aggregated intrinsic value of approximately $4 million , and 20,400 stock options exercised in 2017 with an aggregate intrinsic value less than $1 million . There were 635,196 performance-based stock options granted in the year ended December 31, 2018 , and 1,396,307 performance-based stock options granted in the year ended December 31, 2017 . On May 31, 2018 , we granted an aggregate of 31,184 performance-based stock options under our 2008 Stock Incentive Plan to new senior officers. The options will all vest on the third anniversary of the grant date, subject to achieving a closing stock price of at least $44.29 (a 25% premium above the grant date closing stock price of $35.43) for at least 20 consecutive trading days within three years of the grant date, and will expire on the tenth anniversary of the grant date. On February 28, 2018 , we granted an aggregate of 604,012 performance-based stock options under our 2008 Stock Incentive Plan to certain of our senior officers. The stock options will all vest on the third anniversary of the grant date because, in the three months ended June 30, 2018, the requirement that our stock close at a price of at least $25.75 (a 25% premium above the grant date closing stock price of $20.60) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date.

On March 1, 2017 , we granted 987,781 stock options to certain of our senior officers. These stock options will all vest on the third anniversary of the grant date because, in the three months ended June 30, 2018, the requirement that our stock close at a price of at least $23.74 (a 25% premium above the grant date closing stock price of $18.99) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date. On September 29, 2017 , we granted our executive chairman 408,526 performance-based stock options. The options all vested on the first anniversary of the grant date because, in the three months ended June 30, 2018, the requirement that our stock close at a price of at least $20.53 (a 25% premium above the grant date closing stock price of $16.43) for at least 30 consecutive trading days within four years of the grant date was met; these options will expire on the fifth anniversary of the grant date.

The weighted average estimated fair value of stock options we granted during the year ended December 31, 2018 and 2017 was $9.16 and $7.64 per share, respectively. These fair values were calculated based on each grant date, using a Monte Carlo simulation with the following assumptions:

	February 28, 2018	September 29, 2017	March 1, 2017
Expected volatility	46%	46%	49%
Expected dividend yield	0%	0%	0%
Expected life	6.2 years	3.0 years	6.2 years
Expected forfeiture rate	0%	0%	0%
Risk-free interest rate	2.72%	1.92%	2.15%

The following table summarizes information about our outstanding stock options at December 31, 2018 :

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	82,409	0.2 years	$ 4.56	82,409	$ 4.56
$4.57 to $19.759	1,285,795	6.7 years	$ 18.18	413,960	$ 16.46
$19.76 to $35.430	894,539	7.4 years	$ 21.83	270,668	$ 22.94
	2,262,743	**6.7 years**	**$ 19.12**	**767,037**	**$ 17.47**

As of December 31, 2018 , 71.5% of all our outstanding options were held by current employees and 28.5% were held by former employees. Of our outstanding options, 21.7% were in-the-money, that is, they had exercise price less than the $17.14 market price of our common stock on December 31, 2018 , and 78.3% were out-of-the-money, that is, they had an exercise price of more than $17.14 as shown in the table below:

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	469,849	95.7%	1,147,105	64.7%	1,616,954	71.5%
Former employees	21,086	4.3%	624,703	35.3%	645,789	28.5%
Totals	**490,935**	**100.0%**	**1,771,808**	**100.0%**	**2,262,743**	**100.0%**
% of all outstanding options	**21.7%**		**78.3%**		**100.0%**	

Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2018 , 2017 and 2016 :

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2015	3,627,232	$ 44.69
Granted	1,626,329	30.05
Vested	(1,644,616)	42.95
Forfeited	(434,412)	38.59
Unvested at December 31, 2016	3,174,533	$ 38.75
Granted	714,018	18.25
Vested	(1,397,953)	35.50
Forfeited	(236,610)	32.13
Unvested at December 31, 2017	2,253,988	$ 35.20
Granted	765,184	24.74
Vested	(995,331)	32.63
Forfeited	(139,711)	36.01
Unvested at December 31, 2018	**1,884,130**	**$ 32.25**

In the year ended December 31, 2018 , we granted 765,184 restricted stock units, of which 288,325 will vest and be settled ratably over a three-year period from the grant date, 339,806 will vest and be settled ratably over two-year period from the grant date, and 60,963 will vest and be settled on the third anniversary of the grant date. In addition, in May 2018, we made an annual grant of 54,198 restricted stock units to our non-employee directors for the 2018-2019 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. Because the Board of Directors appointed two new members in May 2018, we made initial grants totaling 3,670 restricted stock units to these directors, as well as prorated annual grants totaling 12,154 restricted stock units. Both the initial grants and the annual grants vested immediately; however, the initial grants will not settle until the directors' separation from the Board, while the annual grants settle on the third anniversary of the grant date. In addition, we granted 6,068 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of specified three-year performance goals for the years 2018 to 2020. Provided the goals are achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 6,068 units granted, depending on our level of achievement with respect to the performance goals.

In the year ended December 31, 2017 , we granted 714,018 restricted stock units of which 518,229 will vest and be settled ratably over a three -year period from the grant date. In addition, in May 2017, we made an annual grant of 145,179 restricted stock units to our non-employee directors for the 2017-2018 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. Because the Board of Directors appointed three new members, one in October 2017 and two in November 2017, we made initial grants totaling 13,772 restricted stock units to these directors, as well as prorated annual grants totaling 23,935 restricted stock units. Both the initial grants and the annual grants vested immediately; however, the initial grants will not settle until the directors' separation from the Board, while the annual grants settle on the third anniversary of the grant date. In addition, we granted 12,903 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of specified three-year performance goals for the years 2017 to 2019. Provided the goals are achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 12,903 units granted, depending on our level of achievement with respect to the performance goals.

As of December 31, 2018 , there were $18 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 1.5 years.

USPI Management Equity Plan

USPI maintains a separate management equity plan whereby it has granted non-qualified options to purchase nonvoting shares of USPI's outstanding common stock to eligible plan participants, allowing the recipient to participate in the incremental growth in the value of USPI from the applicable grant date. The total pool of options consists of approximately 10% of USPI's fully diluted outstanding common stock. Options have an exercise price equal to the estimated fair market value of USPI's common stock on the date of grant, and expire upon the earlier of seven years from the date of grant or July 2022 . The option awards have been structured such that they have a three or four year vesting period in which half of the award vests in equal pro-rata amounts over the applicable vesting period and the remaining half vests at the end of the applicable three or four year period. Any unvested awards are forfeited upon the recipient's termination of service with USPI and vested options must be exercised within 90 days of termination. Once an award is exercised, the recipient must hold the underlying shares for at least six months plus one day and then is eligible to sell the underlying shares to USPI at their estimated fair market value. USPI is only required to purchase any of these eligible nonvoting common shares during a three months window in the third quarter of each calendar year. In addition, at any time after the earlier of (i) July 2022 , or (ii) one year and seven days after all of the options have become exercisable, USPI has the right, but not the obligation, to purchase from each holder of the outstanding shares of nonvoting common stock all or a portion of such shares at their estimated fair market value, provided the shares have been held for the requisite holding period. Payment for USPI's purchase of any eligible nonvoting common shares may be made in cash or in shares of Tenet's common stock. The accompanying Consolidated Statement of Operations for the years ended December 31, 2018 , 2017 and 2016 includes $18 million , $13 million and $10 million , respectively, of pre-tax compensation costs related to USPI's management equity plan.

Employee Stock Purchase Plan

We have an employee stock purchase plan under which we are currently authorized to issue up to 5,062,500 shares of common stock to our eligible employees. As of December 31, 2018 , there were approximately 3.2 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 sold the following numbers of shares under our employee stock purchase plan in the years ended December 31, 2018 , 2017 and 2016 :

	Years Ended December 31,		
	2018	2017	2016
Number of shares	228,045	395,957	217,184
Weighted average price	$ 22.96	$ 17.28	$ 17.21

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, and we match such contributions annually up to a maximum percentage for participants actively employed, as defined by the plan documents. Employer matching contributions will vary by plan. Plan expenses, primarily related to our contributions to the plans, were $99 million , $128 million and $116 million for the years ended December 31, 2018 , 2017 and 2016 , 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 years ended December 31, 2018 and 2017 , the Society of Actuaries issued new mortality improvement scales (MP-2018 and MP-2017, respectively), which we incorporated into the estimates of our defined benefit plan obligations at December 31, 2018 and 2017 . These changes to our mortality assumptions decreased our projected benefit obligations as of December 31, 2018 and 2017 by approximately $4 million and $10 million , respectively. The following tables summarize the balance sheet impact, as well as the benefit obligations, funded status and rate assumptions associated with the SERPs and the DMC Pension Plan based on actuarial valuations prepared as of December 31, 2018 and 2017 :

	December 31,	
	2018	**2017**
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations (1)		
Beginning obligations	$ (1,455)	$ (1,475)
Service cost	(2)	(2)
Interest cost	(56)	(62)
Actuarial gain (loss)	90	(31)
Benefits paid	122	120
Special termination benefit costs	—	(5)
Ending obligations	(1,301)	(1,455)
Fair value of plans assets		
Beginning plan assets	850	786
Gain (loss) on plan assets	(65)	122
Employer contribution	47	43
Benefits paid	(101)	(101)
Ending plan assets	731	850
Funded status of plans	$ (570)	$ (605)
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (49)	$ (69)
Other long-term liability	$ (521)	$ (536)
Accumulated other comprehensive loss	$ 281	$ 266
SERP Assumptions:		
Discount rate	4.50%	3.75%
Compensation increase rate	3.00%	3.00%
Measurement date	December 31, 2018	December 31, 2017
DMC Pension Plan Assumptions:		
Discount rate	4.62%	4.00%
Compensation increase rate	Frozen	Frozen
Measurement date	December 31, 2018	December 31, 2017

(1) The accumulated benefit obligation at December 31, 2018 and 2017 was approximately $1.299 billion and $1.448 billion , respectively.

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

	Years Ended December 31,		
	2018	2017	2016
Service costs	$ 2	$ 2	$ 2
Interest costs	56	62	69
Expected return on plan assets	(54)	(50)	(51)
Amortization of net actuarial loss	14	14	12
Net periodic benefit cost	$ 18	$ 28	$ 32
SERP Assumptions:			
Discount rate	3.75%	4.25%	4.75%
Long-term rate of return on assets	n/a	n/a	n/a
Compensation increase rate	3.00%	3.00%	3.00%
Measurement date	January 1, 2018	January 1, 2017	January 1, 2016
Census date	January 1, 2018	January 1, 2017	January 1, 2016
DMC Pension Plan Assumptions:			
Discount rate	4.00%	4.42%	4.67%
Long-term rate of return on assets	6.50%	6.50%	6.50%
Compensation increase rate	Frozen	Frozen	Frozen
Measurement date	January 1, 2018	January 1, 2017	January 1, 2016
Census date	January 1, 2018	January 1, 2017	January 1, 2016

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. As a result of the adoption of ASU 2017-07 discussed in Note 1, we recognized service costs in salaries, wages and benefits expense, and recognized other components of net periodic benefit cost in other non-operating expense, net, in the accompanying Consolidated Statements of Operations.

We recorded gain (loss) adjustments of $(15) million , $56 million and $(61) million in other comprehensive income (loss) in the years ended December 31, 2018 , 2017 and 2016 , 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 $(29) million , $42 million and $(73) million were recognized during the years ended December 31, 2018 , 2017 and 2016 , respectively, and the amortization of net actuarial loss of $14 million , $14 million and $12 million for the years ended December 31, 2018 , 2017 and 2016 , respectively, were recognized in other comprehensive income (loss). Cumulative net actuarial losses of $281 million , $266 million and $322 million as of December 31, 2018 , 2017 and 2016 , respectively, and unrecognized prior service costs of less than $1 million as of each of the years ended December 31, 2018 , 2017 and 2016 have 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, 2018 , were as follows:

Asset Category	Target	Actual
Cash and cash equivalents	2%	2%
U.S. government obligations	—%	2%
Equity securities	64%	65%
Debt securities	34%	31%
Alternative investments	1%	1%

The DMC Pension Plan assets are invested in separately managed portfolios using investment management firms. The objective for all asset categories is to maximize total return without assuming undue risk exposure. The DMC Pension Plan maintains a well-diversified asset allocation that best meets these objectives. The DMC Pension Plan assets are largely comprised of equity securities, which include companies with various market capitalization sizes in addition to international and convertible securities. Cash and cash equivalents are comprised of money market funds. Debt securities include domestic and foreign government obligations, corporate bonds, and mortgage-backed securities. Under the investment policy of the DMC Pension Plan, investments in derivative securities are not permitted for the sole purpose of speculating on the direction of

market interest rates. Included in this prohibition are leveraging, shorting, swaps, futures, options, forwards and similar strategies.

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, with a rebalancing of the asset allocation occurring at least once per year. The current asset allocation objective is to maintain a certain percentage with each class allowing for a 10% deviation from the target.

The following tables summarize the DMC Pension Plan assets measured at fair value on a recurring basis as of December 31, 2018 and 2017 , 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, 2018	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 33	$ 33	$ —	$ —
U.S. government obligations	9	9	—	—
Equity securities	423	423	—	—
Fixed income funds	262	262	—	—
Futures contracts	4	4	—	—
	$ 731	$ 731	$ —	$ —

	December 31, 2017	Level 1	Level 2	Level 3
Cash and cash equivalents	$ 49	$ 49	$ —	$ —
U.S. government obligations	5	5	—	—
Equity securities	488	488	—	—
Fixed income funds	308	308	—	—
	$ 850	$ 850	$ —	$ —

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	2019	2020	2021	2022	2023	Five Years Thereafter
Estimated benefit payments	$ 897	$ 86	$ 89	$ 90	$ 91	$ 91	$ 450

The SERP and DMC Pension Plan obligations of $570 million at December 31, 2018 are classified in the accompanying Consolidated Balance Sheet as an other current liability ($49 million) and defined benefit plan obligations ($521 million) based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately $49 million for the year ending December 31, 2019 .

NOTE 10. PROPERTY AND EQUIPMENT

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

	December 31,	
	2018	2017
Land	$ 613	$ 602
Buildings and improvements	6,920	6,837
Construction in progress	199	109
Equipment	4,482	4,221
	12,214	11,769
Accumulated depreciation and amortization	(5,221)	(4,739)
Net property and equipment	**$ 6,993**	**$ 7,030**

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

NOTE 11. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying Consolidated Balance Sheets as of 2018 and 2017 :

	2018	2017
Hospital Operations and other		
As of January 1:		
Goodwill	$ 5,406	$ 5,803
Accumulated impairment losses	(2,430)	(2,430)
Total	2,976	3,373
Goodwill acquired during the year and purchase price allocation adjustments	1	5
Goodwill related to assets held for sale and disposed or deconsolidated facilities	3	(402)
Total	**$ 2,980**	**$ 2,976**
As of December 31:		
Goodwill	$ 5,410	$ 5,406
Accumulated impairment losses	(2,430)	(2,430)
Total	**$ 2,980**	**$ 2,976**

	2018	2017
Ambulatory Care		
As of January 1:		
Goodwill	$ 3,437	$ 3,447
Accumulated impairment losses	—	—
Total	3,437	3,447
Goodwill acquired during the year and purchase price allocation adjustments	219	86
Goodwill related to assets held for sale and disposed or deconsolidated facilities	40	(103)
Impact of foreign currency translation	—	7
Total	**$ 3,696**	**$ 3,437**
As of December 31:		
Goodwill	$ 3,696	$ 3,437
Accumulated impairment losses	—	—
Total	**$ 3,696**	**$ 3,437**

	2018	2017
Conifer		
As of January 1:		
Goodwill	$ 605	$ 605
Accumulated impairment losses	—	—
Total	605	605
Goodwill acquired during the year and purchase price allocation adjustments	—	—
Total	**$ 605**	**$ 605**
As of December 31:		
Goodwill	$ 605	$ 605
Accumulated impairment losses	—	—
Total	**$ 605**	**$ 605**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of 2018 and 2017 :

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2018:			
Capitalized software costs	$ 1,667	$ (858)	$ 809
Trade names	102	—	102
Contracts	871	(76)	795
Other	104	(79)	25
Total	**$ 2,744**	**$ (1,013)**	**$ 1,731**
At December 31, 2017:			
Capitalized software costs	$ 1,582	$ (754)	$ 828
Trade Names	102	—	102
Contracts	859	(60)	799
Other	106	(69)	37
Total	**$ 2,649**	**$ (883)**	**$ 1,766**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2018 is as follows:

		Years Ending December 31,					
	Total	2019	2020	2021	2022	2023	Later Years
Amortization of intangible assets	$ 1,053	$ 147	$ 131	$ 112	$ 99	$ 85	$ 479

We recognized amortization expense of $185 million , $172 million and $152 million in the accompanying Consolidated Statements of Operations for the years ended December 31, 2018 , 2017 and 2016 , respectively.

NOTE 12. INVESTMENTS AND OTHER ASSETS

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

	December 31,	
	2018	2017
Marketable securities	$ 40	$ 56
Equity investments in unconsolidated healthcare entities	956	958
Total investments	996	1,014
Cash surrender value of life insurance policies	30	32
Long-term deposits	44	37
California provider fee program receivables	231	266
Land held for expansion, other long-term receivables and other assets	155	194
Investments and other assets	**$ 1,456**	**$ 1,543**

Our policy is to classify investments in debt securities that may be needed for cash requirements as “available-for-sale.” In doing so, the carrying values of debt instruments are adjusted at the end of each accounting period to their market values through a credit or charge to other comprehensive income (loss), net of taxes.

NOTE 13. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

	December 31,	
	2018	2017
Adjustments for defined benefit plans	$ (223)	$ (170)
Foreign currency translation adjustments	—	(38)
Unrealized gains on investments	**$ —**	**$ 4**
Accumulated other comprehensive loss	**$ (223)**	**$ (204)**

The tax benefits allocated to the adjustments for our defined benefit plans and foreign currency translation adjustments were approximately $3 million

and $3 million , respectively, for the year ended December 31, 2018 , and the tax expense

allocated to the adjustments for our defined benefit plans, foreign currency translation adjustments and unrealized gains on investments were approximately $15 million , $5 million , and $3 million , respectively, for the year ended December 31, 2017 . As discussed in Note 1, we recorded cumulative effect adjustments of $36 million and $7 million upon the adoptions of ASU 2018-02 and ASU 2016-01 , respectively, effective January 1, 2018.

NOTE 14. NET OPERATING REVENUES

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

The table below shows our sources of net operating revenues less provision for doubtful accounts and implicit price concessions from continuing operations:

	Years Ended December 31,		
	2018	2017	2016
Hospital Operations and other:			
Net patient service revenues from hospitals and related outpatient facilities			
Medicare	$ 2,882	$ 3,243	$ 3,386
Medicaid	1,294	1,304	1,346
Managed care	9,213	9,583	9,728
Self-pay	96	91	63
Indemnity and other	596	608	604
Total	14,081	14,829	15,127
Physician practices revenues	1,097	1,209	1,201
Health plans	14	110	482
Revenue from other sources	93	112	94
Hospital Operations and other total prior to inter-segment eliminations	**15,285**	**16,260**	**16,904**
Ambulatory Care	**2,085**	**1,940**	**1,797**
Conifer	**1,533**	**1,597**	**1,571**
Inter-segment eliminations	**(590)**	**(618)**	**(651)**
Net operating revenues	**$ 18,313**	**$ 19,179**	**$ 19,621**

Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2018 , 2017 and 2016 by $24 million , $35 million and $54 million , respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Consolidated Balance Sheets (see Note 3). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

The table below shows the composition of net operating revenues less provision for doubtful accounts and implicit price concessions for our Ambulatory Care segment:

	Years Ended December 31,		
	2018	2017	2016
Net patient service revenues	$ 1,965	$ 1,816	$ 1,684
Management fees	92	93	89
Revenue from other sources	28	31	24
Net operating revenues	**$ 2,085**	**$ 1,940**	**$ 1,797**

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

	Years Ended December 31,		
	2018	2017	2016
Revenue cycle services – Tenet	$ 568	$ 583	$ 596
Revenue cycle services – other customers	855	891	839
Other services – Tenet	22	35	55
Other services – other customers	88	88	81
Total revenues from client contracts	**$ 1,533**	**$ 1,597**	**$ 1,571**

Other services represent 7% of Conifer's revenue and include value-based care, consulting and project services.

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 in 2032.

		Years Ending December 31,					
	Total	2019	2020	2021	2022	2023	Later Years
Performance obligations	$ 7,736	$ 585	$ 584	$ 581	$ 581	$ 581	$ 4,824

NOTE 15. 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, 2018 through March 31, 2019, 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, floods and named windstorms, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million . Floods and certain other covered losses, including fires and other perils, have a minimum deductible of $1 million .

Professional and General Liability Reserves

We are self-insured for the majority of our professional and general liability claims and purchase insurance from third-parties to cover catastrophic claims. At December 31, 2018 and 2017 , the aggregate current and long-term professional and general liability reserves in the accompanying Consolidated Balance Sheets were $882 million and $854 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. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.59% , 2.33% and 2.25% at December 31, 2018 , 2017 and 2016 , respectively.

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

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of $388 million , $303 million and $281 million for the years ended December 31, 2018 , 2017 and 2016 , respectively.

NOTE 16. 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 are also subject to a non-prosecution agreement ("NPA"). If we fail to comply with this agreement, we could be subject to criminal prosecution, substantial penalties and exclusion from participation in federal healthcare programs, any of which could adversely impact our business, financial condition, results of operations or cash flows.

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 involved in these matters, especially those involving governmental agencies, and the indeterminate damages sought in some of these matters, 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.

Shareholder Derivative Litigation

In January 2017, the Dallas County District Court consolidated two previously disclosed shareholder derivative lawsuits filed on behalf of the Company by purported shareholders of the Company's common stock against current and former officers and directors into a single matter captioned *In re Tenet Healthcare Corporation Shareholder Derivative Litigation* . The plaintiffs filed a consolidated shareholder derivative petition in February 2017. The consolidated shareholder derivative petition alleged that false or misleading statements or omissions concerning the Company's financial performance and compliance policies, specifically with respect to the previously disclosed civil qui tam litigation and parallel criminal investigation of the Company and certain of its subsidiaries (together, the "Clinica de la Mama matters"), caused the price of the Company's common stock to be artificially inflated. In addition, the plaintiffs alleged that the defendants violated GAAP by failing to disclose an estimate of the possible loss or a range of loss related to the Clinica de la Mama matters. The plaintiffs claimed that they did not make demand on the Company's board of directors to bring the lawsuit because such a demand would have been futile. In May 2018, the judge in the consolidated shareholder derivative litigation entered an order lifting the previous year-long stay of the matter and, in July 2018, the defendants filed pleadings seeking dismissal of the lawsuit. In October 2018, the judge granted defendants' motion to dismiss, but also agreed to give the plaintiffs 30 days to replead their complaint. On January 30, 2019, the court issued a final judgment and order of dismissal after the plaintiffs elected not to replead. The plaintiffs have indicated that they will appeal the court's ruling that dismissal was appropriate because they failed to adequately plead that a pre-suit demand on Tenet's Board of Directors, a precondition to their action, should be excused as futile. The plaintiffs have until March 1, 2019 to file an appeal. If necessary, the defendants intend to continue to vigorously contest the plaintiffs' allegations in this matter.

Antitrust Class Action Lawsuit Filed by Registered Nurses in San Antonio

In *Maderazo, et al. v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al.* , filed in June 2006 in the U.S. District Court for the Western District of Texas, a purported class of registered nurses employed by three unaffiliated San Antonio-area hospital systems allege those hospital systems, including our Baptist Health System, and other unidentified San Antonio regional hospitals violated Section §1 of the federal Sherman Act by conspiring to depress nurses' compensation and exchanging compensation-related information among themselves in a manner that reduced competition and suppressed the wages paid to such nurses. The suit seeks unspecified damages (subject to trebling under federal law), interest, costs and attorneys' fees. On January 23, 2019, the district court issued an opinion denying the plaintiffs' motion for class certification.

On February 5, 2019, the plaintiffs appealed the district court's decision to the U.S. Court of Appeals for the Fifth Circuit. We will continue to vigorously defend ourselves against the plaintiffs' allegations.

Government Investigation of Detroit Medical Center

Detroit Medical Center ("DMC") is subject to an ongoing investigation by the U.S. Attorney's Office for the Eastern District of Michigan and 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 (the "Anti-kickback Statute"), and the federal False Claims Act ("FCA") related to DMC's employment of nurse practitioners and physician assistants ("Mid-Level Practitioners") from 2006 through 2017. As previously disclosed, a media report was published in August 2017 alleging that 14 Mid-Level Practitioners were terminated by DMC earlier in 2017 due to compliance concerns. We are cooperating with the investigation and continue to produce documents on a schedule agreed upon with the DOJ. Because the government's review is in its preliminary stages, we are unable to determine the potential exposure, if any, at this time.

Oklahoma Surgical Hospital Qui Tam Action

In September 2016, a relator filed a qui tam lawsuit under seal in the Western District of Oklahoma against, among other parties, (i) Oklahoma Center for Orthopaedic & Multispecialty Surgery ("OCOM"), a surgical hospital jointly owned by USPI, a healthcare system partner and physicians, (ii) Southwest Orthopaedic Specialists ("SOS"), an independent physician practice group, (iii) Tenet, and (iv) other related entities and individuals. The complaint alleges various violations of the FCA, the Anti-kickback Statute, the Stark law and the Oklahoma Medicaid False Claims Act. In May 2018, Tenet and its affiliates learned that they were parties to the suit when the court unsealed the complaint and the DOJ declined to intervene with respect to the issues involving Tenet, USPI, OCOM and individually named employees. In June 2018, the relator filed an amended complaint more fully describing the claims and adding additional defendants. Tenet, USPI, OCOM and individually named employees filed motions to dismiss the case in October 2018, but the court has not yet ruled on the motions. On February 11, 2019, the court granted a motion brought by the SOS defendants and the relator for a four-month stay so that those parties could continue conferring regarding the issues and claims in the case.

Pursuant to the obligations under our NPA, we reported the unsealed qui tam action to the DOJ, and we are investigating the claims contained in the amended complaint and cooperating fully with the DOJ. Because these proceedings and investigations are in preliminary stages, we are unable to predict with any certainty the terms, or potential impact on our business or financial condition, of any potential resolution of these matters.

Ordinary Course Matters

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

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

The 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, 2018 , 2017 and 2016 . No amounts were recorded in discontinued operations in the 2018, 2017 and 2016 periods.

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2018	$ 12	$ 38	$ (41)	$ (1)	$ 8
Year Ended December 31, 2017	$ 12	$ 23	$ (23)	$ —	$ 12
Year Ended December 31, 2016	$ 299	$ 293	$ (582)	$ 2	$ 12

For the years ended December 31, 2018 , 2017 and 2016 , we recorded net costs of $38 million , $23 million and $293 million , respectively, in connection with significant legal proceedings and governmental investigations. Of these amounts, $278 million for the year ended December 31, 2016 was attributable to accruals for the Clinica de la Mama matters.

NOTE 17. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

As part of the acquisition of United Surgical Partners International, Inc., we entered into a put/call agreement (the "Put/Call Agreement") with respect to the equity interests in USPI held by our joint venture partners. In April 2016, we paid $127 million to purchase shares put to us according to the Put/Call Agreement, which increased our ownership interest in USPI to approximately 56.3% . On May 1, 2017, we amended and restated the Put/Call Agreement to provide for, among other things, the acceleration of our acquisition of certain shares of USPI. Under the terms of the amendment, we paid Welsh Carson, on July 3, 2017, $716 million for the purchase of these shares, which increased our ownership interest in USPI to 80.0% , as well as the final adjustment to the 2016 purchase price. In April 2018, we paid $630 million for the purchase of an additional 15% ownership interest in USPI and the final adjustment to the 2017 purchase price, which increased our ownership interest in USPI to 95% .

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

Based on the nature of these put/call structures, the minority shareholders' interests in USPI are classified as redeemable noncontrolling interests in the accompanying Consolidated Balance Sheets at December 31, 2018 and 2017 .

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the years ended 2018 and 2017 :

	December 31,	
	2018	2017
Balances at beginning of period	**$ 1,866**	**$ 2,393**
Net income	190	239
Distributions paid to noncontrolling interests	(142)	(128)
Accretion of redeemable noncontrolling interests	173	33
Purchases and sales of businesses and noncontrolling interests, net	(667)	(671)
Balances at end of period	**$ 1,420**	**$ 1,866**

Our redeemable noncontrolling interests balances at December 31, 2018 and 2017 in the table above were comprised of $431 million and $519 million , respectively, from our Hospital Operations and other segment, $713 million and $1.137 billion , respectively, from our Ambulatory Care segment, and $276 million and $210 million , respectively, from our Conifer segment. Our net income (loss) attributable to redeemable noncontrolling interests for the years ended December 31, 2018 and 2017 respectively, in the accompanying Consolidated Statements of Operations were comprised of $(25) million and $18 million , respectively, from our Hospital Operations and other segment, $151 million and $170 million , respectively, from our Ambulatory Care segment, and $64 million and $51 million , respectively, from our Conifer segment.

NOTE 18. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2018 , 2017 and 2016 consists of the following:

	Years Ended December 31,		
	2018	2017	2016
Current tax expense (benefit):			
Federal	$ (6)	$ (4)	$ 12
State	33	23	14
	27	19	26
Deferred tax expense (benefit):			
Federal	159	202	34
State	(10)	(2)	7
	149	200	41
	$ 176	**$ 219**	**$ 67**

A reconciliation between the amount of reported income tax expense and the amount computed by multiplying income (loss) 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, 2018 includes $9 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 $9 million is included for the year ended December 31, 2018 to reflect the reduction in the valuation allowance. Foreign pre-tax loss for the years ended December 31, 2018 and 2017 was $6 million and $70 million , respectively.

	Years Ended December 31,		
	2018	2017	2016
Tax expense (benefit) at statutory federal rate of 21% in 2018 (35% in 2017 and 2016)	$ 134	$ (35)	$ 87
State income taxes, net of federal income tax benefit	23	4	16
Expired state net operating losses, net of federal income tax benefit	9	28	35
Tax attributable to noncontrolling interests	(70)	(113)	(106)
Nondeductible goodwill	8	109	29
Nontaxable gains	—	—	(11)
Nondeductible litigation costs	—	—	37
Impact of decrease in federal tax rate on deferred taxes	(1)	246	—
Reversal of permanent reinvestment assumption and other adjustments related to divestiture of foreign subsidiary	(6)	(30)	—
Stock-based compensation tax deficiencies	5	15	—
Changes in valuation allowance (including impact of decrease in federal tax rate)	76	—	(25)
Change in tax contingency reserves, including interest	(1)	(6)	(9)
Prior-year provision to return adjustments and other changes in deferred taxes	(5)	4	12
Other items	4	(3)	2
Income tax expense	**$ 176**	**$ 219**	**$ 67**

In December 2017, the President signed into law the Tax Cuts and Jobs Act (the "Tax Act"). The Tax Act amended the Internal Revenue Code to reduce tax rates and modify policies, credits and deductions for individuals and businesses. For businesses, the Tax Act made broad and complex changes to the U.S. tax code, including but not limited to (1) reducing the corporate federal tax rate from a maximum of 35% to a flat 21% rate effective January 1, 2018, (2) repealing the corporate alternative minimum tax ("AMT") and changing how existing AMT credits may be realized, (3) creating a new limitation on the deductibility of interest expense, (4) allowing full expensing of certain capital expenditures, and (5) denying deductions for performance-based compensation paid to certain key executives. International provisions in the Tax Act have not had, and are not expected to have, a material impact on the Company's taxes.

The staff of the U.S. Securities and Exchange Commission issued Staff Accounting Bulletin No. 118 ("SAB 118"), which provided guidance on accounting for the tax effects of the Tax Act. Pursuant to SAB 118, companies were permitted up to one year from the enactment of the Tax Act to complete the accounting under ASC 740 ("the measurement period"). We completed the accounting for the tax effects of the Tax Act within the measurement period.

As a result of the reduction in the corporate income tax rate from 35% to 21% under the Tax Act, we revalued our net deferred tax assets at December 31, 2017, resulting in a reduction in the value of our net deferred tax assets by approximately $251 million . For the year ended December 31, 2017, we recorded $252 million as a provisional estimate of the impact of the Tax Act, including the decrease in the corporate income tax rate from 35% to 21%. Approximately $6 million of the total $252 million increase in income tax expense is included in the net change in valuation allowance, with the remaining $246 million shown in the table above. During the year ended December 31, 2018 , we recorded $1 million of tax benefit upon finalizing our accounting for the income tax effects of the Tax Act based on actual 2017 federal and state income tax filings.

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, 2018		December 31, 2017	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ —	$ 297	$ —	$ 411
Reserves related to discontinued operations and restructuring charges	24	—	15	—
Receivables (doubtful accounts and adjustments)	155	—	134	—
Deferred gain on debt exchanges	—	—	—	6
Accruals for retained insurance risks	205	—	225	—
Intangible assets	—	341	—	330
Other long-term liabilities	39	—	97	—
Benefit plans	255	—	268	—
Other accrued liabilities	32	—	42	—
Investments and other assets	—	83	—	79
Interest expense limitation	89	—	—	—
Net operating loss carryforwards	266	—	399	—
Stock-based compensation	24	—	27	—
Other items	88	32	142	32
	1,177	**753**	**1,349**	**858**
Valuation allowance	(148)	—	(72)	—
	$ 1,029	**$ 753**	**$ 1,277**	**$ 858**

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

	December 31,	
	2018	2017
Deferred income tax assets	$ 312	$ 455
Deferred tax liabilities	(36)	(36)
Net deferred tax asset	**$ 276**	**$ 419**

During the year ended December 31, 2018 , the valuation allowance increased by $76 million , including an increase of $89 million due to limitations on deductions of interest expense , a decrease of $9 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, and a decrease of $4 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2018 was $148 million . During the year ended December 31, 2017 , we had no net change in the valuation allowance, but there was a decrease of $28 million due to the expiration or worthlessness of unutilized state net operating loss carryovers, an increase of $6 million due to the decrease in the federal tax rate, and an increase of $22 million due to changes in expected realizability of deferred tax assets. The remaining balance in the valuation allowance at December 31, 2017 was $72 million . During the year ended December 31, 2016, the valuation allowance decreased by $24 million primarily due to the expiration or worthlessness of unutilized state net operating loss carryovers. The balance in the valuation allowance as of December 31, 2016 was $72 million .

We account for uncertain tax positions in accordance with 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, 2018 , 2017 and 2016 . 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, 2018 , 2017 and 2016 .

	Continuing Operations
Balance At December 31, 2015	**$ 40**
Additions for prior-year tax positions	2
Reductions due to a lapse of statute of limitations	(7)
Balance At December 31, 2016	**$ 35**
Additions for prior-year tax positions	31
Reductions for tax positions of prior years	(15)
Reductions due to a lapse of statute of limitations	(5)
Balance At December 31, 2017	**$ 46**
Reductions due to a lapse of statute of limitations	(1)
Balance At December 31, 2018	**$ 45**

The total amount of unrecognized tax benefits as of December 31, 2018 was $45 million , of which $43 million , if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2018 includes a benefit of $1 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2017 was $46 million , of which $44 million , if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2017 includes a benefit of $5 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2016 was $35 million , of which $32 million , if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2016 includes a benefit of $9 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. Approximately $1 million of interest and penalties related to accrued liabilities for uncertain tax positions related to continuing operations are included in the accompanying Consolidated Statement of Operations for the year ended December 31, 2018 . Total accrued interest and penalties on unrecognized tax benefits as of December 31, 2018 were $3 million , all of which related to continuing operations.

The Internal Revenue Service (“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, 2014 remain subject to audit by the IRS.

As of December 31, 2018 , approximately $10 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

At December 31, 2018 , our carryforwards available to offset future taxable income consisted of (1) federal net operating loss (“NOL”) carryforwards of approximately $1.0 billion pre-tax expiring in 2027 to 2034 , (2) general business credit carryforwards of approximately $26 million expiring in 2023 through 2038, and (3) state NOL carryforwards of approximately $3.1 billion expiring in 2019 through 2038 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $22 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 19. 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, 2018 , 2017 and 2016 . Net earnings available (loss attributable) 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, 2018			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 108	102,110	$ 1.06
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	1,771	(0.02)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 108**	**103,881**	**$ 1.04**
Year Ended December 31, 2017			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (704)	100,592	$ (7.00)
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	**$ (704)**	**100,592**	**$ (7.00)**
Year Ended December 31, 2016			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic losss per share	$ (187)	99,321	$ (1.88)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (187)**	**99,321**	**$ (1.88)**

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the years ended December 31, 2017 and 2016 because we did not report income from continuing operations available to common shareholders in those periods. 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 years ended December 31, 2017 and 2016 , the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 788 and 1,421 for the years ended December 31, 2017 and 2016 , respectively.

NOTE 20. FAIR VALUE MEASUREMENTS

Our non-financial assets and liabilities not permitted or required to be measured at fair value on a recurring basis typically relate to long-lived assets held and used, long-lived assets held for sale and goodwill. We are required to provide additional disclosures about fair value measurements as part of our financial statements for each major category of assets and liabilities measured at fair value on a non-recurring basis. The following tables present this information and indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities, which generally are not applicable to non-financial assets and liabilities. Fair values determined by Level 2 inputs utilize data points that are observable, such as definitive sales agreements, appraisals or established market values of comparable assets. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability and include situations where there is little, if any, market activity for the asset or liability, such as internal estimates of future cash flows.

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	December 31, 2018	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	$ 39	$ —	$ 39	$ —
Long-lived assets held and used	$ 130	$ —	$ 130	$ —

	December 31, 2017	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	$ 456	$ —	$ 456	$ —
Long-lived assets held and used	$ —	$ —	$ —	$ —
Other than temporarily impaired equity method investments	$ 113	$ —	$ 113	$ —

As described in Note 6 , in the year ended December 31, 2018 , we recorded impairment charges in continuing operations of $40 million for the write-down of buildings and other long-lived assets to their estimated fair values at two hospitals. We also recorded $24 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities, as well as $9 million of impairment charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $4 million related to other impairment charges. In the year ended December 31, 2017 , we recorded $364 million for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen, our Philadelphia-area facilities and certain of our Chicago-area facilities, as well as $31 million of impairment charges related to investments and $7 million related to other intangible assets, primarily contract-related intangibles and capitalized software costs not associated with the hospitals described above.

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, 2018 and 2017 , the estimated fair value of our long-term debt was approximately 97.3% and 100.2% , respectively, of the carrying value of the debt.

NOTE 21. ACQUISITIONS

During the year ended December 31, 2018 , we acquired ten outpatient businesses (all of which are owned by USPI), three off-campus emergency departments and various physician practices. The fair value of the consideration conveyed in the acquisitions (the “purchase price”) was $113 million .

During the year ended December 31, 2017 , we acquired eight outpatient businesses (all of which are owned by USPI) and various physician practices. The fair value of the consideration conveyed in the acquisitions (the “purchase price”) was $50 million .

During the year ended December 31, 2016 , we completed a transaction that allowed us to consolidate five microhospitals that were previously recorded as equity method investments. We also acquired majority interests in 28 ambulatory surgery centers (all of which are owned USPI) and various physician practices. The fair value of the consideration conveyed in the acquisitions (the “purchase price”) was $117 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 2018 is preliminary. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, other intangible assets and noncontrolling interests for some of our 2018 acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed.

Preliminary or final purchase price allocations for all the acquisitions made during the years ended December 31, 2018 , 2017 and 2016 are as follows:

	2018	2017	2016
Current assets	$ 6	$ 7	$ 51
Property and equipment	19	9	38
Other intangible assets	9	8	7
Goodwill	220	91	464
Other long-term assets, including previously held equity method investments	(18)	(3)	(56)
Current liabilities	—	(8)	(30)
Long-term liabilities	(15)	(2)	(15)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(21)	(29)	(190)
Noncontrolling interests	(85)	(18)	(119)
Cash paid, net of cash acquired	(113)	(50)	(117)
Gains on consolidations	**$ 2**	**$ 5**	**$ 33**

The goodwill generated from these transactions, the majority of which will not be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. Of the total $220 million of goodwill recorded for acquisitions completed during the year ended December 31, 2018 , $1 million was recorded in our Hospital Operations and other segment, and $219 million was recorded in our Ambulatory Care segment. Approximately $10 million , $6 million and $20 million in transaction costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2018 , 2017 and 2016 , 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, 2018 , 2017 and 2016 , we recognized gains totaling $2 million , $5 million and $33 million , respectively, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

NOTE 22. SEGMENT INFORMATION

Our business consists of our Hospital Operations and other 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 and other segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 5 , certain of our facilities were classified as held for sale in the accompanying Consolidated Balance Sheet at December 31, 2018 . At December 31, 2018 , our subsidiaries operated 68 hospitals (three of which have since been divested), primarily serving urban and suburban communities in 10 states.

Our Ambulatory Care segment is comprised of the operations of USPI and included nine Aspen facilities in the United Kingdom until their divestiture effective August 17, 2018. At December 31, 2018 , USPI had interests in 255 ambulatory surgery centers, 36 urgent care centers operated under the CareSpot brand, 23 imaging centers and 23 surgical hospitals in 27 states. At December 31, 2018 , we owned 95.0% of USPI.

Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities . At December 31, 2018 , Conifer provided services to approximately 750 Tenet and non-Tenet hospitals and other clients nationwide. In 2012, we entered into agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer. The pricing terms for the services provided by each party to the other under these contracts were based on estimated third-party pricing terms in effect at the time the agreements were signed. At December 31, 2018 , we owned 76.2% of Conifer Health Solutions, LLC, which is the principal subsidiary of Conifer Holdings, Inc.

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

	December 31, 2018	December 31, 2017	December 31, 2016
Assets:			
Hospital Operations and other	$ 15,684	$ 16,466	$ 17,871
Ambulatory Care	5,711	5,822	5,722
Conifer	1,014	1,097	1,108
Total	**$ 22,409**	**$ 23,385**	**$ 24,701**

	Years Ended December 31,		
	2018	2017	2016
Capital expenditures:			
Hospital Operations and other	$ 527	$ 625	$ 799
Ambulatory Care	68	60	51
Conifer	22	22	25
Total	**$ 617**	**$ 707**	**$ 875**
Net operating revenues:			
Hospital Operations and other total prior to inter-segment eliminations	$ 15,285	$ 16,260	$ 16,904
Ambulatory Care	2,085	1,940	1,797
Conifer			
Tenet	590	618	651
Other clients	943	979	920
Total Conifer revenues	1,533	1,597	1,571
Inter-segment eliminations	(590)	(618)	(651)
Total	**$ 18,313**	**$ 19,179**	**$ 19,621**
Equity in earnings of unconsolidated affiliates:			
Hospital Operations and other	$ 10	$ 4	$ 9
Ambulatory Care	140	140	122
Total	**$ 150**	**$ 144**	**$ 131**
Adjusted EBITDA:			
Hospital Operations and other	$ 1,411	$ 1,462	$ 1,586
Ambulatory Care	792	699	615
Conifer	357	283	277
Total	**$ 2,560**	**$ 2,444**	**$ 2,478**
Depreciation and amortization:			
Hospital Operations and other	$ 685	$ 736	$ 709
Ambulatory Care	68	84	91
Conifer	49	50	50
Total	**$ 802**	**$ 870**	**$ 850**
Adjusted EBITDA	**$ 2,560**	**$ 2,444**	**$ 2,478**
Income (loss) from divested and closed businesses (i.e., the Company's health plan businesses)	9	(41)	(37)
Depreciation and amortization	(802)	(870)	(850)
Impairment and restructuring charges, and acquisition-related costs	(209)	(541)	(202)
Litigation and investigation costs	(38)	(23)	(293)
Interest expense	(1,004)	(1,028)	(979)
Gain (loss) from early extinguishment of debt	1	(164)	—

Other non-operating expense, net	(5)	(22)	(20)
Net gains on sales, consolidation and deconsolidation of facilities	127	144	151
Income (loss) from continuing operations, before income taxes	**$ 639**	**$ (101)**	**$ 248**

NOTE 23. RECENT ACCOUNTING STANDARDS

Recently Issued Accounting Standards

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)" ("ASU 2016-02"), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and current GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under current GAAP. Under ASU 2016-02, lessees and lessors are required to recognize and measure leases at the beginning of the earliest period presented using a modified retrospective approach, which includes a number of optional practical expedients. In July 2018, the FASB issued ASU 2018-11 "Leases (Topic 842) Targeted Improvements," which allows lessees and lessors to recognize and measure leases at the beginning of the period of adoption without modifying the comparative period financial statements. This guidance will be effective for us beginning in 2019, and we intend to use the retrospective method as of the period of adoption rather than the earliest period presented meaning that our financial statements for periods prior to January 1, 2019 will not be modified for the application of the new lease accounting standard. We will elect the three packaged transition practical expedients under ASC 842-10-65-1(f) and the practical expedient that allows lessees to choose to not separate lease and non-lease components by class of underlying asset. We expect that, as of January 1, 2019, our consolidated assets and liabilities will both increase by approximately $750 million to $800 million related to on-balance sheet recognition of right of use assets and liabilities. Right of use assets associated with operating leases will be included as an intangible asset, and liabilities associated with operating leases will be split between our other current liabilities and other long-term liabilities in our consolidated balance sheets. We are still finalizing our calculation of the cumulative effect of accounting change we will recognize upon adoption. We are currently working to complete the implementation of new processes and information technology tools to assist in our ongoing lease data collection and analysis, and updating our accounting policies and internal controls in connection with the adoption of the new standard.

In August 2018, the FASB issued ASU 2018-13, "Fair Value Measurement (Topic 820) Disclosure Framework—Changes to the Disclosure Requirements for Fair Value Measurement" ("ASU 2018-13"), which applies to all entities that are required to make disclosures about recurring or nonrecurring fair value measurements. The amendments in ASU 2018-13, which remove, modify or add certain disclosure requirements as part of the FASB's disclosure framework project to improve the effectiveness of the notes to the financial statements, are effective for us beginning in 2020. The adoption of this guidance will not impact our financial position, results of operations or cash flows.

Also in August 2018, the FASB issued ASU 2018-14, "Compensation – Retirement Benefits – Defined Benefit Plans –General (Subtopic 715-20) Disclosure Framework—Changes to the Disclosure Requirements for Defined Benefit Plans" ("ASU 2018-14"), which applies to all employers that sponsor defined benefit pension or other postretirement plans. The amendments in ASU 2018-14, which remove, modify or add certain disclosure requirements as part of the FASB's disclosure framework project to improve the effectiveness of the notes to the financial statements, are effective for us beginning in 2021. The adoption of this guidance will not impact our financial position, results of operations or cash flows.

Additionally, the FASB issued 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 2018-14"), which applies to all entities that are a customer in a hosting arrangement that is a service contract. The amendments in ASU 2018-14, which align the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software, are effective for us beginning in 2020. We do not expect adoption of this guidance to have a material effect on our financial position, results of operations or cash flows.

Recently Adopted Accounting Standards

Effective January 1, 2018, as further discussed in Note 1, we adopted ASU 2014-09 and ASU 2016-01, and we early adopted ASU 2018-02. Also effective January 1, 2018, we adopted ASU 2016-15, "Statement of Cash Flows (Topic 230) Classification of Certain Cash Receipts and Cash Payments" and ASU 2016-18, "Statement of Cash Flows (Topic 230) Restricted Cash," both of which were applied using a retrospective transition method to each period presented and did not have any effect on our statements of cash flows.

Effective January 1, 2017, as further discussed in Note 1, we adopted ASU 2016-09 and early adopted ASU 2017-07. We also early adopted ASU 2017-04, "Intangibles – Goodwill and Other (Topic 350)" ("ASU 2017-04") for our annual goodwill impairment tests for the year ended December 31, 2017. The amendments in ASU 2017-04 modified the concept of impairment from the condition that exists when the carrying amount of goodwill exceeds its implied fair value to the condition that exists when the carrying amount of a reporting unit exceeds its fair value. An entity no longer determines goodwill

impairment by calculating the implied fair value of goodwill by assigning the fair value of a reporting unit to all of its assets and liabilities as if that reporting unit had been acquired in a business combination. Because these amendments eliminate Step 2 from the goodwill impairment test, they should reduce the cost and complexity of evaluating goodwill for impairment. Our adoption of ASU 2017-04 did not affect our financial position, results of operations or cash flows.

NOTE 24. SUBSEQUENT EVENT

On February 5, 2019, we sold $1.5 billion aggregate principal amount of 6.250% senior secured second lien notes, which will mature on February 1, 2027 (the "2027 Senior Secured Second Lien Notes"). We will pay interest on the 2027 Senior Secured Second Lien Notes semi-annually in arrears on February 1 and August 1 of each year, which payments will commence on August 1, 2019. The proceeds from the sale of the 2027 Senior Secured Second Lien Notes were used, after payment of fees and expenses, together with cash on hand and borrowings under our Credit Agreement, to fund the redemption of all $300 million aggregate principal amount of our outstanding 6.750% senior notes due 2020 and all $750 million aggregate principal amount of our outstanding 7.500% senior secured second lien notes due 2022, and will be used to fund the repayment upon maturity of all $468 million aggregate principal amount of our outstanding 5.500% senior unsecured notes due March 1, 2019. In connection with the redemptions, we expect to record a loss from early extinguishment of debt of approximately $47 million in the three months ending March 31, 2019 , primarily related to the difference between the redemption prices and the par values of the notes, as well as the write-off of the associated unamortized issuance costs. As a result of these refinancing transactions, our 5.500% senior unsecured notes due 2019 are not included in current portion of long-term debt in our Consolidated Balance Sheet at December 31, 2018 .

SUPPLEMENTAL FINANCIAL INFORMATION

SELECTED QUARTERLY FINANCIAL DATA
(UNAUDITED)

	Year Ended December 31, 2018			
	First	Second	Third	Fourth
Net operating revenues	$ 4,699	$ 4,506	$ 4,489	$ 4,619
Net income	$ 191	$ 108	$ 65	$ 102
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ 99	$ 26	$ (9)	$ (5)
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic	$ 0.98	$ 0.25	$ (0.09)	$ (0.04)
Diluted	$ 0.96	$ 0.25	$ (0.09)	$ (0.04)

	Year Ended December 31, 2017			
	First	Second	Third	Fourth
Net operating revenues	$ 4,813	$ 4,802	$ 4,586	$ 4,978
Net income (loss)	$ 36	$ 32	$ (289)	$ (99)
Net loss attributable to Tenet Healthcare Corporation common shareholders	$ (53)	$ (55)	$ (367)	$ (229)
Loss per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic	$ (0.53)	$ (0.55)	$ (3.64)	$ (2.27)
Diluted	$ (0.53)	$ (0.55)	$ (3.64)	$ (2.27)

Quarterly operating results are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated implicit price concessions; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; gains (losses) on sales, consolidation and deconsolidation of facilities; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains (losses) from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: changes in federal and state healthcare regulations; the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; hospital performance data on quality measures and patient satisfaction, as well as standard charges for services; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

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 91 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 92 herein.

There were no changes in our internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Certain 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 executive officers appears under Item 1, Business – Executive Officers, of Part I of this report, and information concerning our Standards of Conduct, by which all of our employees, 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 AND FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The Consolidated Financial Statements and notes thereto can be found on pages 94 through 139.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 151).

All other schedules and financial statements of the Registrant are omitted because they are not applicable or not required or because the required information is included in the Consolidated Financial Statements or notes thereto.

FINANCIAL STATEMENTS REQUIRED BY RULE 3-09 OF REGULATION S-X

The consolidated financial statements of Texas Health Ventures Group, L.L.C. and subsidiaries ("THVG"), which are included due to the significance of the equity in earnings of unconsolidated affiliates we recognized from our investment in THVG for the years ended December 31, 2018 , 2017 and 2016 can be found on pages F-1 through F-19.

All other schedules and financial statements of THVG are omitted because they are not applicable or not required or because the required information is included in the Consolidated Financial Statements or notes thereto.

EXHIBITS

Unless otherwise indicated, the following exhibits are filed with this report:

(3) Articles of Incorporation and Bylaws

(a) Amended and Restated Articles of Incorporation of the Registrant, as amended and restated May 8, 2008 (Incorporated by reference to Exhibit 3(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, filed August 5, 2008)

(b) Certificate of Change Pursuant to NRS 78.209, filed with the Nevada Secretary of State effective October 10, 2012 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K filed October 11, 2012)

(c) Certificate of Designation of Series R Preferred Stock, par value $0.15 per share, dated August 31, 2017 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K filed September 1, 2017)

(d) Certificate of Withdrawal of Certificate of Designation of Series R Preferred Stock, par value $0.15 per share, dated March 5, 2018 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K filed March 5, 2018)

(e) 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) 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)

(b) 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)

(c) Fifteenth Supplemental Indenture, dated as of October 16, 2012, by and 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 4.750% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K filed October 16, 2012)

(d) Sixteenth Supplemental Indenture, dated as of October 16, 2012, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 6.750% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed October 16, 2012)

(e) Seventeenth Supplemental Indenture, dated as of February 5, 2013, by and 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 4.500% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K filed February 5, 2013)

(f) Twentieth Supplemental Indenture, dated as of May 30, 2013, by and 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 4.375% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K filed May 31, 2013)

(g) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6.000% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K filed October 1, 2013)

(h) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6.000% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed October 1, 2013)

(i) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8.125% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K filed October 1, 2013)

(j) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8.125% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed October 1, 2013)

(k) Twenty-Fourth Supplemental Indenture, dated as of September 29, 2014, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 5.500% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed September 29, 2014)

(l) 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)

(m) 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)

(n) Twenty-Eighth Supplemental Indenture, dated as of December 1, 2016, 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 7.500% Senior Secured Second Lien Notes due 2022 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed December 1, 2016)

(o) 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)

(p) 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)

(q) Senior Secured Second Lien Notes Indenture, dated as of June 14, 2017, between THC Escrow Corporation III and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 5.125% Senior Secured Second Lien Notes due 2025 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed June 16, 2017)

(r) Unsecured Notes Indenture, dated as of June 14, 2017, between THC Escrow Corporation III and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 7.000% Senior Notes due 2025 (Incorporated by reference to Exhibit 4.5 to Registrant's Current Report on Form 8-K filed June 16, 2017)

(s) Supplemental Indenture, dated as of July 14, 2017, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A. relating to 5.125% Senior Secured Second Lien Notes Due 2025 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K filed July 17, 2017)

(t) Supplemental Indenture, dated as of August 1, 2017, among the Registrant and The Bank of New York Mellon Trust Company, N.A. relating to 7.000% Senior Notes Due 2025 (Incorporated by reference to Exhibit 4.5 to Registrant's Current Report on Form 8-K filed August 2, 2017)

(u) 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)

(10) Material Contracts

(a) Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed October 20, 2010)

(b) Amendment No. 1, dated as of November 29, 2011, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed December 1, 2011)

(c) Amendment No. 2, dated as of January 23, 2014, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10(c) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2013, filed February 24, 2014)

(d) Amendment No. 3, dated as of December 4, 2015, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto and Citicorp USA, Inc., as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed December 9, 2015)

(e) 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)

(f) 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)

(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 pledgers 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

(n) Sixth Amendment to Stock Pledge Agreement, dated as of June 14, 2017, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto

(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

(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 pledgers party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed March 5, 2009)

(q) Exchange and Registration Rights Agreement, dated as of February 5, 2019, among the Registrant, certain of its subsidiaries and Barclays Capital Inc. as representative of the other initial purchasers of the Notes named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed February 6, 2019)

(r) Settlement Agreement among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the Department of Health and Human Services, the State of Georgia, the State of South Carolina, the Registrant, Tenet HealthSystem Medical, Inc., Tenet HealthSystem GB, Inc. n/k/a Atlanta Medical Center, Inc., North Fulton Medical Center, Inc., Tenet HealthSystem Spalding, Inc. n/k/a Spalding Regional Medical Center, Inc., and Hilton Head Health System, L.P., and Ralph D. Williams (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed October 3, 2016)

(s) Non-Prosecution Agreement among Tenet HealthSystem Medical, Inc., the United States Department of Justice and the United States Attorney's Office for the Northern District of Georgia (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed October 3, 2016)

(t) First Amendment to Non-Prosecution Agreement between Tenet HealthSystem Medical, Inc. and the United States Department of Justice (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018, filed August 6, 2018)

(u) Support Agreement, dated March 23, 2018, between the Registrant and Glenview Capital Management, LLC, Glenview Capital Partners, L.P., Glenview Capital Master Fund, Ltd., Glenview Institutional Partners, L.P., Glenview Offshore Opportunity Master Fund, Ltd. and Glenview Capital Opportunity Fund (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 26, 2018)

(v) Employment Agreement, dated March 24, 2018, by and between the Registrant and Ronald A. Rittenmeyer (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K filed March 26, 2018)*

(w) Employment Agreement, dated November 27, 2018, by and between the Registrant and Saumya Sutaria, M.D. (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed November 30, 2018)*

(x) Letter from the Registrant to Keith B. Pitts dated June 21, 2013 (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2013, filed February 24, 2014)*

(y) Letter from the Registrant to J. Eric Evans, dated March 22, 2016 (Incorporated by reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016, filed May 2, 2016)*

(z) 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)*

(aa) 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)*

(bb) Tenet Fourth Amended and Restated Executive Severance Plan, as amended and restated effective August 8, 2018*

(cc) Tenet Healthcare Corporation Tenth Amended and Restated Supplemental Executive Retirement Plan, as amended and restated effective April 1, 2018*

(dd) Ninth Amended and Restated Tenet 2001 Deferred Compensation Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(g) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(ee) Fifth Amended and Restated Tenet 2006 Deferred Compensation Plan, as amended and restated effective January 1, 2019*

(ff) Fifth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(i) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(gg) Form of Stock Award used to evidence grants of stock options and/or restricted units under the Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan (Incorporated by reference to Exhibit 10.3 to Registrant's Current Report on Form 8-K filed February 17, 2006)*

(hh) 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)*

(ii) 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)*

(jj) 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)*

(kk) 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)*

(ll) Terms and Conditions of Restricted Stock Unit Award granted to Ronald A. Rittenmeyer under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018, filed April 30, 2018)*

(mm) Terms and Conditions of Restricted Stock Unit Award granted to Ronald A. Rittenmeyer on June 29, 2018 under the Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(b) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018, filed August 6, 2018)*

(nn) 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)*

(oo) Third Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective March 16, 2017 (Incorporated by reference to Exhibit 10(ll) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2017, filed February 26, 2018)*

(pp) Seventh Amended and Restated Tenet Executive Retirement Account, as amended and restated effective as of April 1, 2018*

(qq) Form of Indemnification Agreement entered into with each of the Registrant's directors (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, filed November 1, 2005)

(21) Subsidiaries of the Registrant

(23) Consents

(a) Consent of Deloitte & Touche LLP

(b) Consent of PricewaterhouseCoopers LLP

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

(a) Certification of Ronald A. Rittenmeyer, Executive Chairman and Chief Executive Officer

(b) Certification of Daniel J. Cancelmi, Chief Financial Officer

(32) Section 1350 Certifications of Ronald A. Rittenmeyer, Executive Chairman and Chief Executive Officer, and Daniel J. Cancelmi, Chief Financial Officer

(101 SCH) XBRL Taxonomy Extension Schema Document

(101 CAL) XBRL Taxonomy Extension Calculation Linkbase Document

(101 DEF) XBRL Taxonomy Extension Definition Linkbase Document

(101 LAB) XBRL Taxonomy Extension Label Linkbase Document

(101 PRE) XBRL Taxonomy Extension Presentation Linkbase Document

(101 INS) 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.

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* 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 25, 2019 By: /s/ R. SCOTT RAMSEY

R. Scott Ramsey
Vice President and 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 25, 2019 By: /s/ RONALD A. RITTENMEYER

Ronald A. Rittenmeyer
Executive Chairman and Chief Executive Officer
(Principal Executive Officer)

Date: February 25, 2019 By: /s/ DANIEL J. CANCELMI

Daniel J. Cancelmi
Chief Financial Officer
(Principal Financial Officer)

Date: February 25, 2019 By: /s/ R. SCOTT RAMSEY

R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Date: February 25, 2019 By: /s/ LLOYD J. AUSTIN, III

Lloyd J. Austin, III
Director

Date: February 25, 2019 By: /s/ JAMES L. BIERMAN

James L. Bierman
Director

Date: February 25, 2019 By: /s/ RICHARD FISHER

Richard Fisher
Director

Date: February 25, 2019 By: /s/ MEGHAN M. FITZGERALD

Meghan M. FitzGerald, DrPH
Director

Date: February 25, 2019 By: /s/ BRENDA J. GAINES

Brenda J. Gaines
Director

Date: February 25, 2019 By: /s/ EDWARD A. KANGAS

Edward A. Kangas
Director

Date: February 25, 2019 By: /s/ J. ROBERT KERREY

J. Robert Kerrey
Director

Date: February 25, 2019 By: /s/ RICHARD MARK

Richard Mark
Director

Date: February 25, 2019 By: /s/ TAMMY ROMO

Tammy Romo
Director

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Additions Charged To: Costs and Expenses (1)(2)	Deductions (3)	Other Items (4)(5)	Balance at End of Period
Allowance for doubtful accounts:					
Year ended December 31, 2018	$ 898	$ —	$ —	$ (898)	$ —
Year ended December 31, 2017	$ 1,031	$ 1,434	$ (1,445)	$ (122)	$ 898
Year ended December 31, 2016	$ 887	$ 1,451	$ (1,307)	$ —	$ 1,031
Valuation allowance for deferred tax assets:					
Year ended December 31, 2018	$ 72	$ 76	$ —	$ —	$ 148
Year ended December 31, 2017	$ 72	$ —	$ —	$ —	$ 72
Year ended December 31, 2016	$ 96	$ (24)	$ —	$ —	$ 72

(1) Includes amounts recorded in discontinued operations.
(2) Before considering recoveries on accounts or notes previously written off.
(3) Accounts written off.
(4) Acquisition and divestiture activity in 2017.
(5) Valuation account eliminated in 2018 upon adoption of new accounting standard ASC 606.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

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Report of Independent Auditors

To the Board of Managers of
Texas Health Ventures Group, L.L.C.

We have audited the accompanying consolidated financial statements of Texas Health Ventures Group, L.L.C. and its subsidiaries, which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of income, changes in equity and cash flows for each of the three years in the period ended June 30, 2018.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Texas Health Ventures Group, L.L.C. and its subsidiaries as of June 30, 2018 and 2017, and the results of their operations and their cash flows for each of the three years in the period ended June 30, 2018 in accordance with accounting principles generally accepted in the United States of America.

/s/ PricewaterhouseCoopers LLP

Dallas, Texas
December 20, 2018

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS – JUNE 30, 2018 AND 2017

(in thousands)

	2018	2017
ASSETS		
CURRENT ASSETS:		
Cash	$ 29,041	$ 32,105
Funds due from USPI	114,408	93,848
Patient receivables, net of allowance for doubtful accounts of $60,631 and $44,306 at June 30, 2018 and 2017, respectively	107,426	91,455
Supplies	26,070	22,167
Prepaid and other current assets	8,533	5,340
Total current assets	285,478	244,915
NON-CURRENT ASSETS:		
Property and equipment, net (Note 2)	238,054	159,680
Restricted cash	4,439	9,960
Investments in unconsolidated affiliates (Note 3)	6,987	7,143
Goodwill and intangible assets, net (Note 5)	431,828	320,048
Other	505	230
Total assets	$ 967,291	$ 741,976
LIABILITIES AND EQUITY		
CURRENT LIABILITIES:		
Accounts payable, including funds due to USPI of $16,014 and $11,568 at June 30, 2018 and 2017, respectively	$ 87,153	$ 62,941
Accrued expenses and other	43,163	41,716
Current portion of long-term obligations (Note 6)	19,789	20,809
Total current liabilities	150,105	125,466
NON-CURRENT LIABILITIES:		
Long-term obligations, net of current portion (Note 6)	174,228	157,470
Other liabilities	17,159	14,635
Total liabilities	341,492	297,571
COMMITMENTS AND CONTINGENCIES (Notes 6, 7, 8 and 9)		
NONCONTROLLING INTERESTS - REDEEMABLE	172,416	109,147
EQUITY:		
Members' equity	419,870	296,074
Noncontrolling interests – nonredeemable	33,513	39,184
Total equity	453,383	335,258
Total liabilities and equity	$ 967,291	$ 741,976

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

FOR THE YEARS ENDED JUNE 30, 2018, 2017 AND 2016

(in thousands)

	2018	2017	2016
REVENUES:			
Net patient service revenue	$ 1,204,516	$ 1,073,887	$ 941,248
Less provision for doubtful accounts	34,636	27,135	16,909
Net patient service revenue less provision for doubtful accounts	1,169,880	1,046,752	924,339
Other revenue	3,653	3,038	7,886
Total revenues	1,173,533	1,049,790	932,225
EQUITY IN EARNINGS OF UNCONSOLIDATED AFFILIATES (Note 3)	5,065	3,965	3,861
OPERATING EXPENSES:			
Salaries, benefits, and other employee costs	277,721	244,798	216,400
Medical services and supplies	284,386	249,158	226,905
Management and royalty fees (Note 8)	41,973	38,530	35,432
Professional fees	8,679	7,785	7,327
Purchased services	56,829	47,549	40,091
Other operating expenses	137,252	121,832	102,142
Provision for doubtful accounts	25,244	22,503	21,739
Impairment loss	—	—	5,667
Depreciation and amortization	31,829	28,605	29,830
Total operating expenses	863,913	760,760	685,533
Operating income	314,685	292,995	250,553
NONOPERATING INCOME (EXPENSES):			
Interest expense	(14,091)	(15,586)	(15,069)
Interest income (Note 8)	711	492	364
Other income /(expense), net	1,059	(1,825)	(350)
Net income before income taxes	302,364	276,076	235,498
INCOME TAXES	(5,099)	(5,036)	(4,103)
Net income	297,265	271,040	231,395
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS – REDEEMABLE	(143,580)	(134,905)	(117,018)
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS – NONREDEEMABLE	(8,648)	(8,229)	(136)
Net income attributable to THVG	$ 145,037	$ 127,906	$ 114,241

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY

FOR THE YEARS ENDED JUNE 30, 2018, 2017 AND 2016

(in thousands)

		Members' Equity			
	Equity	USP	BUMC	Total Members' Equity	Noncontrolling Interests - Nonredeemable
Balance at June 30, 2015	$ 253,720	$ 115,909	$ 116,374	$ 232,283	$ 21,437
Net income	114,377	57,006	57,235	114,241	136
Distributions to members	(105,103)	(50,121)	(50,321)	(100,442)	(4,661)
Contributions from members	52,039	16,904	16,975	33,879	18,160
Purchase of noncontrolling interests	(811)	(400)	(401)	(801)	(10)
Sale of noncontrolling interests	(914)	(1,113)	(1,116)	(2,229)	1,315
Balance at June 30, 2016	313,308	138,185	138,746	276,931	36,377
Net income	136,135	63,825	64,081	127,906	8,229
Distributions to members	(129,002)	(60,778)	(61,022)	(121,800)	(7,202)
Contributions from members	13,571	6,772	6,799	13,571	—
Purchase of noncontrolling interests	(1,160)	(718)	(720)	(1,438)	278
Sale of noncontrolling interests	2,406	451	453	904	1,502
Balance at June 30, 2017	335,258	147,737	148,337	296,074	39,184
Net income	153,685	72,373	72,664	145,037	8,648
Distributions to members	(132,424)	(63,076)	(63,329)	(126,405)	(6,019)
Contributions from members	102,545	51,169	51,376	102,545	—
Purchase of noncontrolling interests	(5,456)	674	676	1,350	(6,806)
Sale of noncontrolling interests	(225)	633	636	1,269	(1,494)
Balance at June 30, 2018	$ 453,383	$ 209,510	$ 210,360	$ 419,870	$ 33,513

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2018, 2017 AND 2016
(in thousands)

	2018	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income	$ 297,265	$ 271,040	$ 231,395
Adjustments to reconcile net income to net cash provided by operating activities:			
Provision for doubtful accounts	59,880	49,638	38,648
Depreciation and amortization	31,829	28,605	29,830
Amortization of debt issue costs	5	5	7
Equity in earnings of unconsolidated affiliates, net of distributions received	156	645	(232)
Loss on fixed asset impairment	—	—	5,667
(Gain) loss on sale of assets	(2)	405	(67)
Changes in operating assets and liabilities, net of effects from purchases of new businesses:			
Increase in patient receivables	(62,006)	(47,022)	(56,096)
Increase in supplies, prepaids, and other assets	(4,639)	3,362	(8,503)
(Decrease) /Increase in accounts payable, accrued expenses, and other liabilities	7,980	11,890	20,739
Net cash provided by operating activities	330,468	318,568	261,388
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchases of new businesses and equity interests, net of cash received of $925, $0 and $394 for 2018, 2017 and 2016, respectively	925	(3,853)	(8,912)
Purchases of property and equipment	(42,172)	(16,950)	(17,686)
Sale of property and equipment	206	1,233	160
Change in deposits and notes receivables	(44)	(5)	9
Other investing activities	13	751	—
Change in funds due from United Surgical Partners, Inc.	(21,158)	(10,416)	(12,794)
Net cash used in investing activities	(62,230)	(29,240)	(39,223)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from debt obligations	$ 26,078	$ 223	$ 4,624
Payments on debt obligations	(49,029)	(19,364)	(15,975)
Distributions to noncontrolling interest owners	(144,265)	(144,576)	(114,429)
Purchases of noncontrolling interests	(8,215)	(5,447)	(3,861)
Sales of noncontrolling interests	9,609	18,445	2,272
Contribution from members	20,925	—	8,912
Distributions to members	(126,405)	(121,800)	(100,442)
Net cash used in financing activities	(271,302)	(272,519)	(218,899)
INCREASE IN CASH	(3,064)	16,809	3,266
CASH, beginning of period	32,105	15,296	12,030
CASH, end of period	$ 29,041	$ 32,105	$ 15,296
SUPPLEMENTAL INFORMATION:			
Cash paid for interest	$ 13,991	$ 15,642	$ 15,113
Cash paid for income taxes	$ 5,076	$ 4,525	$ 3,779
NONCASH TRANSACTIONS:			
Assets acquired under capital leases	$ 32,033	$ 4,791	$ 3,232
Increase in accounts payable due to property and equipment received but not paid	12,322	44	427
Sunnyvale acquisition	—	—	24,967

Tyler acquisition	81,620	—	—
Centennial acquisition	—	13,571	—
Restricted cash borrowed	—	9,960	—
Restricted cash used for purchases of equipment	5,521	—	280
Restricted cash used for payments on debt obligations	—	—	2,089

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Texas Health Ventures Group, L.L.C. and subsidiaries (THVG or the Company), a Texas limited liability company, was formed on January 21, 1997, for the primary purpose of developing, acquiring, and operating ambulatory surgery centers and related entities. THVG is a joint venture between Baylor University Medical Center (BUMC), an affiliate of Baylor Scott & White Holdings (BSW Holdings), who owns 50.1% of THVG and USP North Texas, Inc. (USP), a Texas corporation and consolidated subsidiary of United Surgical Partners International, Inc. (USPI), who owns 49.9% of THVG. USPI is a subsidiary of Tenet Healthcare Corporation. BSW Holdings and its "controlled" affiliates are referred collectively herein as "BSWH". THVG's fiscal year ends June 30. Fiscal years of THVG's subsidiaries end December 31; however, the financial information of these subsidiaries included in these consolidated financial statements is as of June 30, 2018 and 2017, and for the years ended, June 30, 2018, 2017 and 2016.

THVG owns equity interests in and operates ambulatory surgery centers, surgical hospitals, and related businesses in the Dallas/Fort Worth, Texas, metropolitan area. At June 30, 2018, THVG operated thirty-three facilities (the Facilities) under management contracts, thirty-two of which are consolidated for financial reporting purposes and one of which is accounted for under the equity method. THVG also has an equity method investment in a facility that does not fall under a management contract. In addition, THVG holds an equity method investment in one partnership that owns the real estate used by one of the Facilities.

THVG has been funded by capital contributions from its members and by cash distributions from the Facilities. The board of managers, which is controlled by BSWH, initiates requests for capital contributions. The Facilities' operating agreements provide that cash flows available for distribution will be distributed, at least quarterly, to THVG and other owners of the Facilities.

THVG's operating agreement provides that the board of managers determine, on at least a quarterly basis, if THVG should make a cash distribution based on a comparison of THVG's excess cash on hand versus current and anticipated needs, including, without limitation, needs for operating expenses, debt service, acquisitions, and a reasonable contingency reserve. The terms of THVG's operating agreement provide that any distributions, whether driven by operating cash flows or by other sources, such as the distribution of noncash assets or distributions in the event THVG liquidates, are to be shared according to each member's overall ownership level in THVG.

Change in Reporting Entity

From January 1, 2016 to March 1, 2018, BUMC had a 60% controlling interest in Texas Regional Medical Center, LLC (Sunnyvale), through a separate joint venture with Tenet Healthcare Corporation (Tenet). On March 1, 2018, that joint venture was restructured and Sunnyvale was combined with THVG upon contribution by the Company's members. On March 1, 2018, USP paid BUMC and Tenet approximately $4,100,000 each for its interest in Sunnyvale resulting in THVG owning a controlling 62% interest.

The transfer of ownership interests in Sunnyvale qualifies as a common control transaction as defined by ASC 250-10-45-21 as BSWH held a controlling interest in the hospital before the transaction and continues to hold a controlling interest subsequent to the transaction. As a result, the commonly controlled entities, inclusive of Sunnyvale, which historically have not been presented together are considered to be a different reporting entity. This change in reporting entity requires retrospective combination of the entities for all periods presented as if the combination had been in effect since inception of common control. For the period prior to Sunnyvale's contribution into THVG, net income attributable to non-controlling interest was calculated at the percentage used for the previous joint venture, 40%. The Company's historical consolidated balance sheets and related statements of income, changes in equity, and of cash flows and related disclosures, include Sunnyvale starting with BUMC's acquisition of Sunnyvale on January 1, 2016. The effect of the change on Net income attributable to THVG for the years ended 2018, 2017, and 2016 was approximately $2,900,000, $1,800,000, and $5,500,000, respectively.

Basis of Accounting

THVG maintains its books and records on the accrual basis of accounting, and the consolidated financial statements are prepared in accordance with accounting principles generally accepted in the United States.

Principles of Consolidation

The consolidated financial statements include the financial statements of THVG and its wholly owned subsidiaries and other entities that THVG controls. All intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management of THVG to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash Equivalents

THVG considers all highly liquid instruments with original maturities when purchased of three months or less to be cash equivalents. There were no cash equivalents at June 30, 2018, or 2017. Under the Company's cash management system, checks issued but not presented to the bank may result in book cash overdraft balances for accounting purposes. The company reclassifies book overdrafts to accounts payable reflecting the reinstatement of liabilities cleared in the bookkeeping process. Book overdrafts are non-cash by their nature and as such, changes in accounts payable, including those caused by book overdrafts, are reflected as an adjustment to reconcile net income to net cash provided by operating activities in the consolidated statements of cash flows. Book overdrafts included in accounts payable were approximately $24,118,000 and $12,730,000, as of June 30, 2018 and 2017, respectively.

Restricted Cash

THVG holds cash from debt agreements for construction projects that is considered restricted. The funds are restricted for the purpose of completing the construction project or to pay back the related debt, drawn for the project. Restricted cash balances were approximately $4,439,000 and $9,960,000 as of June 30, 2018 and 2017, respectively, and are classified as non-current, consistent with the nature of their intended use based on the restrictions.

Patient Receivables

Patient receivables are stated at estimated net realizable value. Significant concentrations of patient receivables at June 30, 2018 and 2017 include:

	2018	2017
Commercial and managed care providers	48%	51%
Government-related programs	32%	35%
Self-pay patients	20%	14%
	100%	100%

Government-related programs (i.e. Medicare and Medicaid) represent the only concentrated groups of payors from which THVG has significant outstanding receivables, and management does not believe there is any significant or unusual level of credit risk associated with these receivables. Commercial and managed care receivables consist of receivables from various payors involved in diverse activities and subject to differing economic conditions, and do not represent any concentrated credit risk to THVG. THVG maintains allowances for uncollectible accounts for estimated losses resulting from the payors' inability to make payments on accounts. THVG assesses the reasonableness of the allowance account based on historic write-offs, cash collections, the aging of the accounts and other current conditions and economic factors. Furthermore, management continually monitors and adjusts the allowances associated with its receivables. Accounts are written off when collection efforts have been exhausted.

Supplies

Supplies, consisting primarily of pharmaceuticals and medical supplies inventories, are stated at the lower of cost or net realizable value, which approximates market value, and are expensed as used.

Property and Equipment

Property and equipment are initially recorded at cost or, when acquired as part of a business combination, at fair value at the date of acquisition. Depreciation is calculated on the straight line method over the estimated useful lives of the assets. Upon retirement or disposal of assets, the asset and accumulated depreciation accounts are adjusted accordingly, and any gain or loss is reflected in earnings or losses of the respective period. Maintenance costs and repairs are expensed as incurred; significant renewals and betterments are capitalized.

Assets held under capital leases are classified as property and equipment and amortized using the straight line method over the shorter of the useful lives or the lease terms, and the related obligations are recorded as debt. Amortization of property and equipment

held under capital leases and leasehold improvements is included in depreciation and amortization expense in the consolidated statements of income.

THVG records operating lease expense on a straight-line basis unless another systematic and rational allocation is more representative of the time pattern in which the leased property is physically employed. THVG amortizes leasehold improvements, including amounts funded by landlord incentives or allowances, for which the related deferred rent is amortized as a reduction of lease expense, over the shorter of their economic lives or the lease term.

Investments in Unconsolidated Affiliates

Investments in unconsolidated affiliates in which THVG exerts significant influence, but has less than a controlling ownership, are accounted for under the equity method. THVG exerts significant influence in the operations of its unconsolidated affiliates through representation on the governing bodies of the investees and additionally, with respect to the Facilities, through contracts to manage the operations of the investees.

Equity in earnings of unconsolidated affiliates consists of THVG's share of the profits and losses generated from its noncontrolling equity investments. Because these operations are central to THVG's business strategy, equity in earnings of unconsolidated affiliates is classified as a component of operating income in the accompanying consolidated statements of income.

Goodwill

Goodwill represents the excess purchase price over the estimated fair value of net identifiable assets acquired and liabilities assumed from purchased businesses. Goodwill is not amortized but is instead tested for impairment annually, and between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. The qualitative assessment includes a determination by management based on qualitative factors as to whether it is more likely than not that the fair value of the reporting unit is less than its carrying amount. If management determines that based on these factors it is more likely than not that the fair value of the reporting unit is less than its carrying value, the Company assesses its goodwill based on the two-step fair value approach.

To measure the amount of an impairment loss, a two-step method is used. In the first step, THVG compares the fair value of each reporting unit to its carrying value. If the fair value of the reporting unit exceeds the carrying value of the net assets assigned to that unit, goodwill is not impaired and THVG is not required to perform further testing. If the carrying value of the net assets assigned to the reporting unit exceeds the fair value of the reporting unit, then THVG must perform the second step of the impairment test in order to determine the implied fair value of the reporting unit's goodwill. If the carrying value of a reporting unit's goodwill exceeds its implied fair value, then THVG records an impairment loss equal to the difference. Any impairment would be recognized by a charge to income from operations and a reduction in the carrying value of goodwill.

We estimate the fair value of the reporting unit using the market and income approaches. Goodwill is required to be reported at the reporting unit level and we have concluded that THVG represents a single reporting unit. To determine the fair value of the reporting unit, we use the income approach (present value of discounted cash flows) with further corroboration from the market approach (evaluation of market multiples and/or data from third-party valuation specialists). We apply judgment in determining the fair value of our reporting unit which is dependent on significant assumptions and estimates regarding expected future cash flows, terminal value, changes in working capital requirements, and discount rates. The factor most sensitive to change with respect to THVG's discounted cash flow analyses is the estimated future cash flows of the reporting unit which is, in turn, sensitive to THVG's estimates of future revenue growth and margins for these businesses. If actual revenue growth and/or margins are lower than estimated, the impairment test results could differ. Although we believe that our estimates are reasonable and consistent with market participant assumptions, actual results could differ from these estimates.

A qualitative analysis of the goodwill balance was performed in March of 2018 and no such impairments were identified. A quantitative analysis was performed in March 2017 and 2016 and no such impairments were identified.

Impairment of Long-Lived Assets

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset, or related groups of assets, may not be fully recoverable from estimated future cash flows. In the event of impairment, measurement of the amount of impairment may be based on appraisal, fair values of similar assets, or estimates of future undiscounted cash flows resulting from use and ultimate disposition of the asset. No such impairment was identified in 2018 or 2017. In June of 2016, THVG determined that Lewisville Surgicare Partners, Ltd. (Lewisville), Baylor Surgicare at Ennis, L.L.C.

(Ennis), and Arlington Surgicare Partners, Ltd. (Arlington) would be closing due to poor operational results and expected negative cash flows. This represented a significant adverse change in the manner in which the facilities' assets were being used, thus triggering the need to test the facilities' long-lived assets for impairment. The assets consisted of office and medical equipment, furniture, and building leases. Management determined the fair value of the furniture and equipment is greater than the total carrying value, using Level 2 inputs, and as such no impairment was recorded for those asset groups. Based on the inability to locate a sublessee to occupy the properties, which are specialized to perform outpatient surgery, and Level 3 inputs, THVG concluded that the three facility building leases, which were classified as capital leases, were impaired and an impairment charge was recorded in June 2016 for approximately $5,667,000.

Fair Value of Financial Instruments

The fair value of a financial instrument is the amount at which the instrument could be exchanged in an orderly transaction between market participants to sell the asset or transfer the liability. The Company uses fair value measurements based on quoted prices in active markets for identical assets or liabilities (Level 1), significant other observable inputs (Level 2) or unobservable inputs (Level 3), depending on the nature of the item being valued. The Company does not have financial assets or liabilities measured at fair value on a recurring basis at June 30, 2018 and 2017. The carrying amounts of cash, restricted cash, funds due from United Surgical Partners, Inc., accounts receivable, and accounts payable approximate fair value because of the short maturity of these instruments.

The fair value of the Company's long-term debt is determined by Level 2 inputs which are an estimation of the discounted future cash flows of the debt at rates currently quoted or offered to a comparable company for similar debt instruments of comparable maturities by its lenders. At June 30, 2018, the aggregate carrying amount and estimated fair value of long-term debt is approximately $54,482,000 and $47,865,000, respectively. At June 30, 2017, the aggregate carrying amount and estimated fair value of long-term debt was approximately $61,864,000 and $58,637,000, respectively.

Revenue Recognition

THVG has agreements with third-party payors that provide for payments to THVG at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amount from patients, third-party payors, and others for services rendered, including estimated contractual adjustments under reimbursement agreements with third party payors. Contractual adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. These contractual adjustments are related to the Medicare and Medicaid programs, as well as commercial and managed care contracts. All subsidiaries of THVG, except for Sunnyvale, assess the ability of each patient to pay prior to the performance of the procedure; therefore the estimate of uncollectable amounts related to these entities is presented within the provision for doubtful accounts within the operating expenses section of the income statement. Sunnyvale does not assess ability to pay prior to the performance of the procedure, and as such the related estimate of uncollectable amounts for this entity is presented within the provision for doubtful accounts as a component of total revenues.

Net patient service revenue from the Medicare and Medicaid programs accounted for approximately 19%, 17%, and 15% of total net patient service revenue in 2018, 2017, and 2016, respectively.

Net patient service revenue from commercial and managed care contracts accounted for approximately 75%, 77%, and 78% of net patient service revenue in 2018, 2017, and 2016, respectively.

Net patient service revenue from private payors accounted for approximately 6%, 6%, and 7% of total net patient service revenue in 2018, 2017, and 2016, respectively. For facilities licensed as hospitals, federal regulations require the submission of annual cost reports covering medical costs and expenses associated with services provided to program beneficiaries. Medicare and Medicaid cost report settlements are estimated in the period services are provided to beneficiaries.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is a reasonable possibility that recorded estimates with respect to the ten THVG facilities licensed as hospitals may change as interpretations are clarified. These initial estimates are revised as needed until final cost reports are settled.

The Company provides charity care to patients who are financially unable to pay for the health care services they receive. The determination of charity care is generally made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of patients to pay. The discount amount is generally based on household income compared to the Federal

Poverty Limit for the year. The Company's charity policy is intended to satisfy the requirements in Section 501(r) of the Internal Revenue Code of 1986, as amended, regarding financial assistance and emergency medical care policies, limitations on charges to persons eligible for financials assistance, and reasonable billing and collection efforts. The Company's policy is not to pursue collection of amounts determined to qualify as charity care; therefore, the Company does not report these amounts in net patient care revenues before provision of doubtful accounts or in provision for doubtful accounts.

The Company's estimated costs (based on the selected operating expenses, which include allocated personnel costs, supplies, other operating expenses, and management fee) of caring for charity care patients for the years ended June 30, 2018, 2017, and 2016, was approximately $7,800,000, $6,100,000, and $3,400,000, respectively.

Income Taxes

No amounts for federal income taxes have been reflected in the accompanying consolidated financial statements because the federal tax effects of THVG's activities accrue to the individual members.

The Texas franchise tax applies to all THVG entities and is reflected in the accompanying consolidated statements of income. The tax is calculated on a margin base and is therefore reflected in THVG's consolidated statements of income for the years ended June 30, 2018, 2017, and 2016 as income tax.

THVG follows the provisions of Accounting Standards Codification (ASC) 740 "Income Taxes" which prescribes a single model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing the minimum recognition threshold a tax position is required to meet before being recognized in the financial statements.

As of June 30, 2018 and 2017, THVG had no gross unrecognized tax benefits. THVG files a partnership income tax return in the U.S. federal jurisdiction and a franchise tax return in the state of Texas. THVG is no longer subject to U.S. federal income tax examination for years prior to 2014 and no longer subject to state and local income tax examination for years prior to 2013. THVG has identified Texas as a "major" state taxing jurisdiction. THVG does not expect or anticipate a significant change over the next twelve months in the unrecognized tax benefits.

Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines and penalties, and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated.

Reclassifications

Certain amounts related to the prior year have been reclassified to conform to the current year presentation.

Recently Issued Accounting Pronouncements

In February 2016, FASB issued ASU 2016-02, " *Leases* (Topic 842)" ("ASU 2016-02"), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and current GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under current GAAP. Recognition of these assets and liabilities will have a material impact to our consolidated balance sheet upon adoption. In transition, lessees and lessors are required to recognize and measure leases at the beginning of the earliest period presented using a modified retrospective approach, which includes a number of optional practical expedients. The Company is currently evaluating the potential impact of this guidance, which will be effective for fiscal years beginning after December 15, 2018.

In May 2014, August 2015, April 2016, May 2016, December 2016, and February 2017, FASB issued ASU 2014-09, " *Revenue from Contracts with Customers (Topic 606)* "; ASU 2015-14, " *Revenue from Contracts with Customers* "; ASU 2016-10, " *Identifying Performance Obligations and Licensing* "; ASU 2016-12, " *Revenue from Contracts with Customers: Narrow-Scope Improvements and Practical Expedients* "; ASU 2016-20, " *Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers* "; and ASU 2017-05, " *Clarifying the Scope of Asset Derecognition Guidance and Accounting for Partial Sales of Nonfinancial Assets* ", respectively, which supersedes the revenue recognition requirements in Accounting Standards Codification (ASC) 605, " *Revenue Recognition.* " These ASU's address when an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in

exchange for those goods or services. The Company is currently evaluating the potential impact of this guidance, which is effective July 1, 2018.

In August 2016, FASB issued ASU 2016-15, *"Classification of Certain Cash Receipts and Cash Payments."* This ASU provides cash flow statement classification guidance. These ASU's are effective for annual reporting periods beginning after December 15, 2017, and may impact the classification of certain items on the statement of income but are not expected to have a material impact on total operating income.

In November 2016, FASB issued ASU 2016-18, " *Restricted Cash: a Consensus of the FASB Emerging Issues Task Force.* " This ASU requires a statement of cash flows to explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. The provisions of ASU 2016-18 are effective for fiscal years beginning after December 15, 2017, and interim periods within those year for public business entities, and December 15, 2018, and interim periods thereafter for all other entities. The Company is currently evaluating the impact of this ASU and believes it will have an immaterial impact on presentation and disclosure.

In January 2017, FASB issued ASU 2017-01, " *Clarifying the Definition of a Business* ." By clarifying the definition of a business, the amendments of this ASU affect all companies and other reporting organizations that must determine whether they have acquired or sold a business. The provisions of ASU 2017-01 are effective for fiscal years beginning after December 15, 2017, and interim periods within those years for public business entities, and December 15, 2018, and interim periods within those years for all other entities. The Company is currently evaluating the impact of this ASU.

In January 2017, FASB issued ASU 2017-04, " *Simplifying the Test for Goodwill Impairment.* " This ASU eliminates Step 2 from the goodwill impairment test. Step 2 measures a goodwill impairment loss by comparing the implied fair value of a reporting unit's goodwill with the carrying amount of that goodwill. The provisions of ASU 2017-04 are effective for fiscal years beginning after December 15, 2019, and interim periods within those years for public business entities, and December 15, 2021, and interim periods within those years for all other entities. The Company is currently evaluating the impact of this ASU.

2.PROPERTY AND EQUIPMENT

At June 30, 2018 and 2017, property and equipment and related accumulated depreciation and amortization consisted of the following (in thousands):

	Estimated Useful Lives	2018	2017
Land	—	$ 1,719	$ 1,568
Buildings and leasehold improvements	5-25 years	258,161	193,885
Equipment	3-15 years	203,672	166,194
Furniture and fixtures	5-15 years	10,547	8,495
Construction in progress		6,397	1,367
		480,496	371,509
Less accumulated depreciation		(242,442)	(211,829)
Net property and equipment		$ 238,054	$ 159,680

At June 30, 2018 and 2017, assets recorded under capital lease arrangements included in property and equipment consisted of the following (in thousands):

	2018	2017
Buildings	$ 143,139	$ 112,401
Equipment and furniture	2,060	218
	145,199	112,619
Less accumulated depreciation	(56,162)	(52,629)
Net property and equipment under capital leases	$ 89,037	$ 59,990

3. INVESTMENTS IN SUBSIDIARIES AND UNCONSOLIDATED AFFILIATES

THVG's investments in consolidated subsidiaries and unconsolidated affiliates consisted of the following:

Legal Name	Facility	City	Percentage Owned		
			June 30, 2018	June 30, 2017	June 30, 2016
Consolidated subsidiaries [1]:					
DeSoto Surgicare, Ltd.	North Texas Surgery Center	Desoto	52.1%	52.1%	52.1%
Metroplex Surgicare Partners, Ltd.	Baylor Surgicare at Bedford	Bedford	65.8	65.8	65.8
Baylor Surgicare at North Dallas, LLC	Baylor Surgicare at North Dallas	Dallas	56.9	56.6	56.6
Fort Worth Surgicare Partners, Ltd.	Baylor Surgical Hospital of Fort Worth	Fort Worth	50.7	50.1	50.9
Denton Surgicare Partners, Ltd.	Baylor Surgicare at Denton	Denton	50.5	50.5	51.0
Garland Surgicare Partners, Ltd.	Baylor Surgicare at Garland	Garland	50.1	50.1	50.1
University Surgical Partners of Dallas, L.L.P. [2]	N/A	Dallas	68.1	66.5	66.2
Dallas Surgical Partners, L.L.C.	Baylor Surgicare	Dallas	54.6	58.9	58.6
MSH Partners, L.L.C.	Baylor Medical Center at Uptown	Dallas	34.9	33.5	33.4
North Central Surgical Center, L.L.P.	North Central Surgery Center	Dallas	34.4	33.4	33.8
Grapevine Surgicare Partners, Ltd.	Baylor Surgicare at Grapevine	Grapevine	53.5	55.2	56.8
Frisco Medical Center, L.L.P.	Baylor Scott & White Medical Center - Frisco	Frisco	50.5	50.4	50.3
Physicians Center of Fort Worth, L.L.P.	Baylor Surgicare at Fort Worth I & II	Fort Worth	54.0	54.1	53.9
Bellaire Outpatient Surgery Center, L.L.P.	Baylor Surgicare at Oakmont	Fort Worth	25.8	26.1	25.5
Park Cities Surgery Center, L.L.C.	Park Cities Surgery Center	Dallas	50.1	50.1	50.1
Trophy Club Medical Center, L.P.	Baylor Medical Center at Trophy Club	Fort Worth	50.7	50.3	50.1
Rockwall/Heath Surgery Center, L.L.P.	Baylor Surgicare at Heath	Heath	—	61.9	59.2
North Garland Surgery Center, L.L.P.	Baylor Surgicare at North Garland	Garland	54.3	52.1	52.1
Rockwall Ambulatory Surgery Center, L.L.P.	Rockwall Surgery Center	Rockwall	54.7	53.3	53.3
Baylor Surgicare at Plano, L.L.C.	Baylor Surgicare at Plano	Plano	50.1	50.1	50.1
Arlington Orthopedic and Spine Hospitals, LLC	Baylor Orthopedic and Spine Hospital at Arlington	Arlington	50.1	50.1	50.1
Baylor Surgicare at Granbury, LLC	Baylor Surgicare at Granbury	Granbury	51.2	51.2	50.6
Metrocrest Surgery Center, L.L.C.	Baylor Surgicare at Carrollton	Carrollton	53.5	53.5	51.0
Baylor Surgicare at Mansfield, L.L.C.	Baylor Surgicare at Mansfield	Mansfield	50.1	50.1	50.3
Tuscan Surgery Center, L.L.C.	Tuscan Surgery Center at Las Colinas	Las Colinas	55.5	57.3	51.0
Lone Star Endoscopy Center, L.L.C.	Lone Star Endoscopy	Keller	51.0	51.0	51.0
Baylor Surgicare at Plano Parkway, L.L.C.	Baylor Surgicare at Plano Parkway	Plano	51.0	51.0	51.0
Texas Endoscopy Centers, LLC	Texas Endoscopy	Plano/Allen	51.0	51.0	51.0
Heritage Park Surgical Hospital, LLC	Baylor Scott & White Surgical Hospital - Sherman	Sherman	52.5	52.5	52.3
Centennial ASC, LLC	Frisco Centennial Surgery Center	Frisco	50.2	50.4	—
Baylor Surgicare at Baylor Plano, LLC	Baylor Plano Campus	Plano	25.3	25.3	—
Texas Spine and Joint Hospital, LLC	Texas Spine and Joint	Tyler	54.5	—	—
Baylor Surgicare at Blue Star, LLC	Frisco Star	Frisco	25.8	—	—
Texas Regional Medical Center, LLC	Sunnyvale Hospital	Sunnyvale	62.1	60.3	60.3

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS- continued

Legal Name	Facility	City	Percentage Owned		
			June 30, 2018	June 30, 2017	June 30, 2016
Unconsolidated affiliates:					
Denton Surgicare Real Estate, Ltd. [3]		n/a	49.0	49.0	49.0
Irving-Coppell Surgical Hospital, L.L.P.	Irving-Coppell Surgical Hospital	Irving	19.3	19.6	18.3
MCSH Real Estate Investors, Ltd. [3]		n/a	2.0	2.0	2.0
Fusionetics, LLC	Fusionetics	Frisco	15.8	15.8	—

1. List excludes holding companies, which are wholly-owned by the Company and hold the Company's investments in the Facilities.
2. Partnership that has investment in North Central Surgical Center, Baylor Surgicare, and Baylor Medical Center at Uptown.
3. These entities are not surgical facilities and do not have ownership in any surgical facilities.

On August 2, 2017, Texas Health Venture Texas Spine, LLC, a wholly-owned subsidiary of THVG, completed its acquisition of Texas Spine and Joint Hospital, LLC (Tyler), resulting in a 50.25% controlling interest. The consideration of $40,900,000 and $40,700,000 was paid to the sellers by BSWH and USP, respectively. From the date of contribution to June 30, 2018, THVG recognized approximately $98,600,000 of total revenues and approximately $5,800,000 of net income from Tyler.

On February 1, 2017, BSWH and USP contributed their respective ownership interests in Centennial ASC, LLC (Centennial) to THVG, resulting in THVG owning a 50.42% controlling interest. The value of the contributions from BSWH and USP was approximately $6,799,000 and $6,772,000, respectively. From the date of contribution to June 30, 2017, THVG recognized approximately $4,400,000 of total revenues and approximately $1,000,000 of net income from Centennial. For the twelve months ended June 30, 2018, THVG recognized approximately $10,300,000 of total revenues and approximately $2,300,000 of net income from Centennial.

The following table summarizes the recorded values of the assets and liabilities as of the respective contribution date (in thousands):

	Tyler Hospital	Centennial
Cash and cash equivalents	$ 925	$ —
Current assets	15,703	3,690
Long-term assets	18,276	1,079
Goodwill	111,831	19,290
Total assets acquired	146,735	24,059
Current liabilities	10,127	585
Long-term liabilities	4,378	—
Total liabilities assumed	14,505	585
Noncontrolling interests	50,610	9,903
Net assets acquired	$ 81,620	$ 13,571

The assets and liabilities were accounted for at their respective fair values at the date of acquisition. Noncontrolling interests (NCI) are valued upon acquisition with a discount to reflect lack of control and marketability by the NCI holders. These fair value measurements are determined by Level 2 inputs. The resulting goodwill is attributed to expected synergies from combining operations. The results of these contributed facilities are included in THVG's consolidated financial statements from the respective dates of contribution.

The following table presents the unaudited pro forma results as if THVG had acquired Tyler and Centennial on July 1, 2016 (in thousands). The pro forma results are not necessarily indicative of the results of operations that would have occurred if the acquisitions were completed on the dates indicated, nor is indicative of the future operating results of THVG.

	Year Ended June 30, 2018	Year Ended June 30, 2017	Year Ended June 30, 2016
Total revenues	$ 1,178,160	$ 1,158,708	$ 1,002,041
Net income attributable to THVG	$ 143,420	$ 133,111	$ 122,178

4. NONCONTROLLING INTERESTS

The Company controls and therefore consolidates the results of 32 of its 34 facilities at June 30, 2018. Similar to its investments in unconsolidated affiliates, the Company regularly engages in the purchase and sale of equity interests with respect to its consolidated subsidiaries that do not result in a change of control. These transactions are accounted for as equity transactions, as they are undertaken among the Company, its consolidated subsidiaries, and noncontrolling interests, and their cash flow effects are classified within financing activities.

During the fiscal year ended June 30, 2018, the Company purchased and sold equity interests in various consolidated subsidiaries in the amounts of approximately $8,215,000 and $9,609,000, respectively. During the fiscal year ended June 30, 2017, the Company purchased and sold equity interests in various consolidated subsidiaries in the amounts of approximately $5,447,000 and $18,445,000, respectively. During the fiscal year ended June 30, 2016, the Company purchased and sold equity interests in various consolidated subsidiaries in the amounts of approximately $3,861,000 and $2,272,000, respectively. The basis difference between the Company's carrying amount and the proceeds received or paid in each transaction is recorded as an adjustment to the Company's equity. The impact of these transactions is summarized as follows (in thousands):

	Year Ended June 30, 2018	Year Ended June 30, 2017	Year Ended June 30, 2016
Net income attributable to the Company	$ 145,037	$ 127,906	$ 114,241
Net transfers to the noncontrolling interests:			
Increase/(Decrease) in the Company's equity for gains/losses related to purchases of subsidiaries' equity interests	1,350	(1,438)	(801)
Increase/(Decrease) in the Company's equity for gains/(losses) related to sales of subsidiaries' equity interests	1,269	904	(2,229)
Net transfers to noncontrolling interests	2,619	(534)	(3,030)
Change in equity from net income attributable to the Company and net transfers to noncontrolling interests	$ 147,656	$ 127,372	$ 111,211

As further described in Note 1, upon the occurrence of various fundamental regulatory changes, the Company could be obligated, under the terms of its investees' partnership and operating agreements, to purchase some or all of the noncontrolling interests related to the Company's consolidated subsidiaries. As a result, these noncontrolling interests are not included as part of the Company's equity and are carried as noncontrolling interests-redeemable on the Company's consolidated balance sheets. The activity in noncontrolling interests-redeemable for the years ended June 30, 2018, 2017 and 2016 is summarized below (in thousands):

Balance, June 30, 2015	$ 79,590
Net income attributable to noncontrolling interests	117,018
Distributions to noncontrolling interests	(109,768)
Purchases of noncontrolling interests	(3,961)
Sales of noncontrolling interests	3,186
Noncontrolling interests attributable to business acquisition	3,862
Balance, June 30, 2016	89,927
Net income attributable to noncontrolling interests	134,905
Distributions to noncontrolling interests	(137,373)
Purchases of noncontrolling interests	(3,631)
Sales of noncontrolling interests	15,415
Noncontrolling interests attributable to business acquisition	9,904
Balance, June 30, 2017	$ 109,147
Net income attributable to noncontrolling interests	143,580
Distributions to noncontrolling interests	(138,245)
Purchases of noncontrolling interests	(2,512)
Sales of noncontrolling interests	9,836
Noncontrolling interests attributable to business acquisition	50,610
Balance, June 30, 2018	$ 172,416

5. GOODWILL

The following is a summary of changes in the carrying amount of goodwill for the years ended June 30, 2018 and 2017 (in thousands):

Balance, June 30, 2016	$	301,019
Additions:		
Centennial ASC		19,290
Adjustments:		
Acquisition of Precision Surgery Center		(532)
Balance, June 30, 2017		319,777
Additions:		
Tyler Spine and Joint		111,831
Balance, June 30, 2018	$	431,608

Goodwill additions resulting from business combinations are recorded and assigned to the parent and noncontrolling interests.

6. LONG-TERM OBLIGATIONS

At June 30, 2018 and 2017, long-term obligations consisted of the following (in thousands):

	2018	2017
Capital lease obligations (Note 7)	$ 139,535	$ 116,415
Notes payable to financial institutions	54,482	61,864
Total long-term obligations	194,017	178,279
Less current portion	(19,789)	(20,809)
Long-term obligations, less current portion	$ 174,228	$ 157,470

The aggregate maturities of notes payable for each of the five years subsequent to June 30, 2018 and thereafter are as follows (in thousands):

2019	$	12,032
2020		13,893
2021		9,586
2022		8,823
2023		6,291
Thereafter		3,857
Total long-term obligations	$	54,482

The Facilities have notes payable to financial institutions which mature at various dates through 2025 and accrue interest at fixed and variable rates ranging from 2% to 8%. Each note is collateralized by certain assets of the respective facility.

Capital lease obligations are collateralized by underlying real estate or equipment and have interest rates ranging from 2% to 13%.

7. LEASES

The Facilities lease various office equipment, medical equipment, and office space under a number of operating lease agreements, which expire at various times through the year 2033. Such leases do not involve contingent rentals, nor do they contain significant renewal or escalation clauses. Office leases generally require the Facilities to pay all executory costs (such as property taxes, maintenance, and insurance).

Minimum future payments under noncancelable leases with remaining terms in excess of one year as of June 30, 2018 are as follows (in thousands):

		Capital Leases	Operating Leases
Year ending June 30:			
	2019	$ 20,648	$ 39,858
	2020	20,298	38,123
	2021	20,443	35,855
	2022	19,800	35,043
	2023	19,321	32,901
Thereafter		126,938	193,486
Total minimum lease payments		227,448	$ 375,266
Amount representing interest		(87,913)	
Total principal payments		$ 139,535	

Total rent expense under operating leases was approximately $48,190,000, $39,445,000, and $34,522,000 for the years ended June 30, 2018, 2017, and 2016, respectively, and is included in other operating expenses in the accompanying consolidated statements of income.

8. RELATED-PARTY TRANSACTIONS

THVG operates the Facilities under management and royalty contracts, and THVG in turn is managed by BSWH and USP, resulting in THVG incurring management and royalty fee expense payable to BSWH and USP in amounts equal to the management and royalty fee income THVG receives from the Facilities. THVG's management and royalty fee income from the facilities it consolidates for financial reporting purposes eliminates in consolidation with the facilities' expense and therefore is not included in THVG's consolidated revenues. THVG's management and royalty fee income from facilities which are not consolidated was $600,000 for years ended June 30, 2018, 2017, and 2016, and is included in other income in the accompanying consolidated statements of income.

The management and royalty fee expense to BSWH and USP was approximately $41,973,000, $38,530,000, and $35,432,000 for the years ended June 30, 2018, 2017, and 2016, respectively, and is reflected in operating expenses in THVG's consolidated statements of income. Of the total, 64.3% and 1.7% represent management fees payable to USP and BSWH, respectively, and 34% represents royalty fees payable to BSWH.

Under the management and royalty agreements, the Facilities pay THVG an amount ranging from 5.0% to 7.0% of their net patient service revenue less provision for doubtful accounts annually, subject, in some cases, to an annual cap.

In addition, a subsidiary of USPI frequently pays bills on behalf of THVG and has custody of substantially all of THVG's excess cash, paying THVG and the Facilities interest income on the net balance at prevailing market rates. Amounts held by USPI on behalf of THVG and the Facilities, shown in Funds due from United Surgical Partners, Inc. on the accompanying consolidated balance sheets, totaled approximately $114,408,000 and $93,848,000 at June 30, 2018 and 2017, respectively. Accrued expenses that USPI paid on behalf of THVG, shown in Accounts payable on the accompanying consolidated balance sheets, totaled approximately $16,014,000 and $11,568,000 at June 30, 2018 and 2017, respectively. The interest income amounted to approximately $334,000, $233,000, and $150,000 for the years ended June 30, 2018, 2017, and 2016, respectively.

9. COMMITMENTS AND CONTINGENCIES

Financial Guarantees

THVG guarantees portions of the indebtedness of its investees to third-parties, which could potentially require THVG to make maximum aggregate payments totaling approximately $3,192,000. Of the total, approximately $1,800,000 relates to the obligations of a consolidated subsidiary whose capital lease obligation is included in THVG's consolidated balance sheets and related disclosures, and approximately $1,392,000 relates to obligations of two consolidated subsidiaries whose operating lease obligations are not included in THVG's consolidated balance sheets.

These arrangements (a) consist of guarantees of real estate and equipment financing, (b) are collateralized by all, or a portion of, the investees' assets, (c) require payments by THVG in the event of a default by the investee primarily obligated under the financing, (d) expire as the underlying debt matures at various dates through 2021, or earlier if certain performance targets are met, and (e) provide no recourse for THVG to recover any amounts from third-parties. The fair value of the guarantee liability was not material to the consolidated financial statements and, therefore, no amounts were recorded at June 30, 2018 related to these guarantees. When THVG incurs guarantee obligations that are disproportionately greater than the guarantees provided by the investee's other owners, THVG charges the investee a fair market value fee based on the value of the contingent liability THVG is assuming.

Litigation and Professional Liability Claims

In their normal course of business, the Facilities are subject to claims and lawsuits relating to patient treatment. THVG believes that its liability for damages resulting from such claims and lawsuits is adequately covered by insurance or is adequately provided for in its consolidated financial statements. USPI, on behalf of THVG and each of the Facilities, maintains professional liability insurance that provides coverage on a claims-made basis of $1,000,000 per incident and $15,000,000 in annual aggregate amount with retroactive provisions upon policy renewal. Certain of THVG's insurance policies have deductibles and contingent premium arrangements. THVG believes that the expense recorded through June 30, 2018, which was estimated based on historical claims, adequately provides for its exposure under these arrangements. Additionally, from time to time, THVG may be named as a party to other legal claims and proceedings in the ordinary course of business. THVG is not aware of any such claims or proceedings that have more than a remote chance of having a material adverse impact on THVG.

10. SUBSEQUENT EVENTS

THVG regularly engages in exploratory discussions or enters into letters of intent with various entities regarding possible joint ventures, development, or other transactions. These possible joint ventures, developments of new facilities, or other transactions are in various stages of negotiation.

THVG has performed an evaluation of subsequent events through December 20, 2018, which is the date the consolidated financial statements were available to be issued.

TENET

FOURTH AMENDED AND RESTATED

EXECUTIVE SEVERANCE PLAN

As Amended and Restated Effective August 8, 2018

FOURTH AMENDED AND RESTATED
EXECUTIVE SEVERANCE PLAN
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FOURTH AMENDED AND RESTATED
EXECUTIVE SEVERANCE PLAN

ARTICLE I
PREAMBLE AND PURPOSE

1.1 Preamble. In January 2003, Tenet Healthcare Corporation (the " **Company** ") adopted the Tenet Executive Severance Protection Plan (the " **TESPP** ") to provide Covered Executives of the Company and its affiliates with certain cash severance payments and/or other benefits in the event of a termination of the executive's employment as a result of a "qualifying termination," as defined in the TESPP, or under certain other circumstances following a "change of control," as defined in the TESPP. Effective May 11, 2006, the Company amended and restated the TESPP to:

(a) expand the classification of employees eligible to participate in such plan;

(b) modify (and in the case of a change of control expand) the severance payments and other benefits payable under such plan on account of a qualifying termination;

(c) amend, restate and replace the associated individual TESPP agreements, the change of control agreements, and the severance provisions of any employment agreements that cover eligible executives with a severance plan agreement, a copy of which was attached to as such amended and restated plan as Appendix B,

(d) revise the definition of change of control;

(e) modify the administration and claims review procedures under the plan;

(f) comply with the requirements of section 409A of the Internal Revenue Code of 1986, as amended (the " **Code** "); and

(g) change the name of the plan to the "Tenet Executive Severance Plan" (the " **ESP** ").

The Company intended that the ESP and Tenet Executive Severance Plan Agreement attached thereto as Appendix A serve as an amendment and restatement of the TESPP, the associated individual TESPP agreements, the change of control agreements and the severance provisions of any employment agreement that covers an eligible executive, as applicable, to comply with the requirements of section 409A of the Code, effective as of January 1, 2005, or, in the case of an individual TESPP agreement, change of control agreement or employment agreement, the effective date of such agreement, if later. To the extent that an executive did not elect to participate in this ESP, such executive's TESPP agreement, change of control agreement or employment agreement, as applicable, remained in effect and was amended to comply with the provisions of section 409A of the Code.

Effective December 31, 2008, the Company amended and restated the ESP effective to comply with final regulations issued under section 409A of the Code. The Company again amended and restated the ESP effective May 9, 2012 to, among other things, revise certain definitions and modify the benefits provided.

The Company subsequently amended and restated the ESP effective November 6, 2013 to delegate to the Senior Vice President, Human Resources and the Plan Administrator the authority to determine the employees eligible to participate in the ESP and the level of severance benefits each employee will receive. This amended and restated ESP was known as the Tenet Third Amended and Restated Executive Severance Plan.

By this instrument, the Company amends and restates the ESP effective August 8, 2018 (the " **Effective Date** "), to clarify the manner in which severance pay will be determined for employees who become eligible (or re-eligible) to participate in the ESP on and after the execution date of this amended and restated ESP and make certain administrative clarifications. This amended and restated ESP will be known as the Tenet Fourth Amended and Restated Executive Severance Plan.

The Company may adopt one or more domestic trusts to serve as a possible source of funds for the payment of benefits under the ESP.

1.2 Purpose. Through the ESP, the Company intends to permit the deferral of compensation and to provide additional benefits to a select group of management or highly compensated employees of the Company and its affiliates. Accordingly, it is intended that the ESP will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Code, nor will it constitute a "funded plan," for purposes of such requirements. It also is intended that the ESP will qualify as a "pension plan" within the meaning of section 3(2) of the Employee Retirement Income Security Act of 1974, as amended (" **ERISA** ") that is exempt from the participation and vesting requirements of Part 2 of Title I of ERISA, the funding requirements of Part 3 of Title I of ERISA, and the fiduciary requirements of Part 4 of Title I of ERISA by reason of the exclusions afforded plans that are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.1 Definitions. When a word or phrase appears in this ESP with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) " **Affiliate** " means a corporation that is a member of a controlled group of corporations (as defined in section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is in common control (as defined in section 414(c) of the Code) with the Company, or any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company.

(b) " **AIP** " means the Company's Annual Incentive Plan, as the same may be amended, restated, modified, renewed or replaced from time to time.

(c) " **Average Bonus** " means the average bonus percent applicable to the Covered Executive under the AIP for three years (or actual period of employment, if less) preceding the year of his Qualifying Termination (subject to a fifty percent (50%) minimum) multiplied by his Base Salary at the time of a Qualifying Termination.

(d) " **Base Salary** " means the Covered Executive's annual gross rate of pay including amounts reduced from the Employee's compensation and contributed on the Employee's behalf as deferrals under any qualified or non-qualified employee benefit plans sponsored by the Employer in effect immediately before a Qualifying Termination. Base Salary **excludes** bonuses, hardship withdrawal allowances, Annual Incentive Plan Awards, housing allowances, relocation payments, deemed income, income payable under the SIP or other stock incentive plans, Christmas gifts, insurance premiums and other imputed income, pensions, and retirement benefits.

(e) " **Board** " means the Board of Directors of the Company.

(f) " **Bonus** " means the amount payable to a Covered Executive, if any, under the AIP.

(g) " **Cause** " means

(i) when used in connection with a Qualifying Termination triggering benefits pursuant to Section 3.1, a Covered Executive's:

(A) dishonesty,

(B) fraud,

(C) willful misconduct,

(D) breach of fiduciary duty,

(E) conflict of interest,

(F) commission of a felony,

(G) material failure or refusal to perform his job duties in accordance with Company policies,

(H) a material violation of Company policy that causes harm to the Company or an Affiliate, or

(I) other wrongful conduct of a similar nature and degree.

A failure to meet or achieve business objectives, as defined by the Company, will not be considered Cause so long as the Covered Executive has devoted his best efforts and attention to the achievement of those objectives.

(ii) when used in connection with a Qualifying Termination triggering benefits pursuant to Section 3.2:

(A) any intentional act or misconduct materially injurious to the Company or any Affiliate, financial or otherwise, but not limited to, misappropriation or fraud, embezzlement or conversion by the Covered Executive of the Company's or any Affiliate's property in connection with the Covered Executive's employment with the Company or an Affiliate,

(B) Any willful act or omission constituting a material breach by the Covered Executive of a fiduciary duty,

(C) A final, non-appealable order in a proceeding before a court of competent jurisdiction or a final order in an administrative proceeding finding that the Covered Executive committed any willful misconduct or criminal activity (excluding minor traffic violations or other minor offenses), which commission is materially inimical to the interests of the Company or any Affiliate, whether for his personal benefit or in connection with his duties for the Company or an Affiliate,

(D) The conviction (or plea of no contest) of the Covered Executive for any felony,

(E) Material failure or refusal to perform his job duties in accordance with Company policies (other than resulting from the Covered Executive's disability as defined by Company policies), or

(F) A material violation of Company policy that causes material harm to the Company or an Affiliate.

A failure to meet or achieve business objectives, as defined by the Company, will not be considered Cause so long as the Covered Executive has devoted his reasonable efforts and attention to the achievement of those objectives. For purposes of this Section, no act or failure to act on the part of the Covered Executive shall be deemed "willful", "intentional" or "knowing" if it was undertaken in reasonable reliance on the advice of counsel or at the instruction of the Company, including but not limited to the Board, a committee of the Board or the Chief Executive Officer (" **CEO** ") of the Company, or was due primarily to an error in judgment or negligence, but shall be deemed "willful", "intentional" or "knowing" only if done or omitted to be done by the Covered Executive not in good faith and without reasonable belief that the Covered Executive's action or omission was in the best interest of the Company.

(iii) A Covered Executive will not be deemed to have been terminated for Cause, under either this Section 2.1(g)(i) or 2.1(g)(ii) above, as applicable, unless and until there has been delivered to the Covered Executive written notice that the Covered Executive has engaged in conduct constituting Cause. The determination of Cause will be made by the Human Resources Committee with respect to any Covered Executive who is employed as the CEO, by the CEO (or an individual acting in such capacity or possessing such authority on an interim basis) with respect to any other Covered Executive except a Hospital Chief Executive Officer (" **Hospital CEO** ") and by the Chief Operating Officer of the Company (the " **COO** ") with respect to any Covered Executive who is employed as a Hospital CEO. A Covered Executive who receives written notice that he has engaged in conduct constituting Cause, will be given the opportunity to be heard (either in person or in writing as mutually agreed to by the Covered Executive and the Human Resources Committee, CEO or COO, as applicable) for the purpose of considering whether Cause exists. If it is determined either at or following such hearing that Cause exists, the Covered Executive will be notified in writing of such determination within five (5) business days. If the Covered Executive disagrees with such determination, the Covered Executive may file a claim contesting such determination pursuant to Article IV within thirty (30) days after his receipt of such written determination finding that Cause exists.

(h) " **Change of Control** " means the occurrence of one of the following:

(i) A "change in the ownership of the Company" which will occur on the date that any one person, or more than one person acting as a group within the meaning of Section 409A of the Code, acquires, directly or indirectly, whether in a single transaction or series of related transactions, ownership of stock in the Company that, together with stock held by such person or group, constitutes more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company (" **Ownership Control** "). However, if any one person or more than one person acting as a group, has previously acquired ownership of more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company, the acquisition of additional stock by the same person or persons will not be

considered a "change in the ownership of the Company" (or to cause a "change in the effective control of the Company" within the meaning of Section 2.1(h)(ii) below). Further, an increase in the effective percentage of stock owned by any one person, or persons acting as a group, as a result of a transaction in which the Company acquires its stock in exchange for cash or property will be treated as an acquisition of stock for purposes of this paragraph; provided, that for purposes of this Section 2.1(h)(i), the following acquisitions of Company stock will not constitute a Change of Control:

(A) any acquisition, whether in a single transaction or series of related transactions, by any employee benefit plan (or related trust) sponsored or maintained by the Company or an Affiliate which results in such employee benefit plan obtaining "Ownership Control" of the Company or

(B) any acquisition, whether in a single transaction or series of related transactions, by the Company which results in the Company acquiring stock of the Company representing "Ownership Control" or

(C) any acquisition, whether in a single transaction or series of related transactions, after which those persons who were owners of the Company's stock immediately before such transaction(s) own more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company (or if after the consummation of such transaction(s) the Company (or another entity into which the Company is merged into or otherwise combined, such the Company does not survive such transaction(s)) is a direct or indirect subsidiary of another entity which itself is not a subsidiary of an entity, then the more than fifty percent (50%) ownership test shall be applied to the voting securities of such other entity) in substantially the same percentages as their respective ownership of the Company immediately before such transaction(s).

This Section 2.1(h)(i) applies either when there is a transfer of the stock of the Company (or issuance of stock) and stock in the Company remains outstanding after the transaction or when there is a transfer of the stock of the Company (including a merger or similar transaction) and stock in the Company does not remain outstanding after the transaction.

(ii) A "change in the effective control of the Company" which will occur on the date that either (A) or (B) occurs:

(A) any one person, or more than one person acting as a group within the meaning of Section 409A of the Code, acquires (taking into consideration any prior acquisitions during the twelve (12) month period ending on the date of the most recent acquisition by such person or persons), directly or indirectly, ownership of stock of the

Company possessing thirty-five percent (35%) or more of the total voting power of the stock of the Company (not considering stock owned by such person or group before such twelve (12) month period) (*i.e.* , such person or group must acquire within a twelve (12) month period stock possessing at least thirty-five percent (35%) of the total voting power of the stock of the Company) (" **Effective Control** "), except for (i) any acquisition by any employee benefit plan (or related trust) sponsored or maintained by the Company or an Affiliate which results in such employee benefit plan obtaining "Effective Control" of the Company or (ii) any acquisition by the Company. The occurrence of "Effective Control" under this Section 2.1(h)(ii)(A) may be nullified by a vote of that number of the members of the Board of Directors of the Company (" **Board** "), that exceeds two-thirds (2/3) of the independent members of the Board, which vote must occur before the time, if any, that a "change in the effective control of the Company" has occurred under Section 2.1(h)(ii)(B) below. In the event of such a supermajority vote, such transaction or series of related transactions shall not be treated as an event constituting "Effective Control". For avoidance of doubt, the ESP provides that in the event of the occurrence of the acquisition of ownership of stock of the Company that reaches or exceeds the thirty-five percent (35%) ownership threshold described above, if more than two-thirds (2/3) of the independent members of the Board take action to resolve that such an acquisition is not a "change in the effective control of the Company" and a majority of the members of the Board have not been replaced as provided under Section 2.1(h)(ii)(B) below, then such Board action shall be final and no "Effective Control" shall be deemed to have occurred for any purpose under the ESP.

(B) a majority of the members of the Board are replaced during any twelve (12) month period by directors whose appointment or election is not endorsed by a majority of the members of the Board before the date of the appointment or election.

For purposes of a "change in the effective control of the Company," if any one person, or more than one person acting as a group, is considered to effectively control the Company within the meaning of this Section 2.1(h)(ii), the acquisition of additional control of the Company by the same person or persons is not considered a "change in the effective control of the Company," or to cause a "change in the ownership of the Company" within the meaning of Section 2.1(h)(i) above.

(iii) A sale, exchange, lease, disposition or other transfer of all or substantially all of the assets of the Company.

(iv) A liquidation or dissolution of the Company that is approved by a majority of the Company's stockholders.

For purposes of this Section 2.1(h), the provisions of section 318(a) of the Code regarding the constructive ownership of stock will apply to determine stock ownership; provided, that, stock underlying unvested options (including options exercisable for stock that is not substantially vested) will not be treated as owned by the individual who holds the option.

(i) " **COBRA** " means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(j) " **Code** " means the Internal Revenue Code of 1986, as amended from time to time and the regulations and rulings issued thereunder.

(k) " **Company** " means Tenet Healthcare Corporation.

(l) " **Covered Executive** " means any Employee who is designated as a Covered Executive by the Senior Vice President, Human Resources or the Plan Administrator who enters into an ESP Agreement or an Employee who satisfied the definition of Covered Executive under the terms of a prior ESP document. To the extent permitted by applicable law, an individual will cease to be a Covered Executive as of the date he attains age sixty-five (65).

(m) " **DCP** " means the Tenet 2001 Deferred Compensation Plan, the Tenet 2006 Deferred Compensation Plan and any other deferred compensation plan maintained by the Employer that covers Covered Executives.

(n) " **Effective Date** " means August 8, 2018.

(o) " **Employee** " means each select member of management or highly compensated employee receiving remuneration, or who is entitled to remuneration, for services rendered to the Employer, in the legal relationship of employer and employee. The term "Employee" does not include a consultant, independent contractor or leased employee even if such consultant, leased employee or independent contractor is subsequently determined by the Employer, the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a common law employee of the Employer. Further, the term "Employee" does not include a person who is receiving severance pay from the Employer.

(p) " **Employer** " means the Company and each Affiliate that has adopted the ESP as a participating employer. Unless provided otherwise by the Human Resources Committee or the Board, all Affiliates will be participating employers in the ESP. Each such Affiliate may evidence its adoption of the ESP either by a formal action of its governing body or taking administrative actions with respect to the ESP on behalf of its Covered Executives (*e.g.* , communicating the terms of the ESP, etc.). An entity will automatically cease to be a participating employer as of the date such entity ceases to be an Affiliate.

(q) " **ERISA** " means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(r) " **ESP** " means the Tenet Executive Severance Plan as set forth herein and as the same may be amended from time to time. The ESP was formerly known as the TESPP.

(s) " **ESP Agreement** " means the written agreement between a Covered Executive and the Plan Administrator, on behalf of the Employer substantially in the form attached hereto in Appendix A. This form ESP Agreement may differ with respect to a Covered Executive who was covered by the TESPP before May 11, 2006 or as determined by the Senior Vice President, Human Resources and/or Plan Administrator (or Human Resources Committee before the Effective Date), each in its sole and absolute discretion as provided in Section 3.6. Each ESP Agreement will form a part of the ESP with respect to the affected Covered Executive.

(t) " **Equity Plan** " means any equity plan, agreement or arrangement maintained or sponsored by the Employer other than the SIP (*e.g.* , the 1999 broad-based stock option plan and the 1995 stock incentive plan).

(u) " **Five Percent Owner** " means any person who owns (or is considered as owning within the meaning of section 318 of the Code as modified by section 416(i)(1)(B)(iii) of the Code) more than five percent (5%) of the outstanding stock of the Company or an Affiliate or stock possessing more than five percent (5%) of the total combined voting power of all stock of the Company or an Affiliate. The rules of sections 414(b), (c) and (m) of the Code will not apply for purposes of applying these ownership rules. Thus, this ownership test will be applied separately with respect to the Company and each Affiliate.

(v) " **401(k) Plan** " means the Tenet Healthcare Corporation 401(k) Retirement Savings Plan or any other qualified retirement plan with a cash or deferred arrangement that is maintained or sponsored by the Employer.

(w) " **409A Exempt Amount** " means that portion of the distributions under the ESP to a Covered Executive that does not exceed two (2) times the **lesser** of:

(i) the sum of the Covered Executive's annualized compensation based upon the annual rate of pay for services provided to the Employer for the taxable year of the Covered Executive preceding the taxable year of the Covered Executive in which he has a Qualifying Termination, provided that such termination constitutes a "separation from service" with such Employer within the meaning of section 409A of the Code (adjusted for any increase during that year that was expected to continue indefinitely if the Covered Executive had not separated from service); or

(ii) the maximum amount that may be taken into account under a qualified plan pursuant to section 401(a)(17) of the Code for the year in which the Covered Executive has a Qualifying Termination, provided that such termination constitutes a "separation from service" within the meaning of section 409A of the Code.

In the event that a Covered Executive is a Key Employee, no distributions in excess of the 409A Exempt Amount will be made during the six (6) month period following the date of the Covered Executive's Qualifying Termination.

(x) " **Good Reason** " means:

(i) In the case of a voluntary termination of employment by a Covered Executive preceding or more than two (2) years following a Change of Control:

(A) a material diminution in the Covered Executive's job authority, responsibilities or duties;

(B) a material diminution of the Covered Executive's Base Salary;

(C) an involuntary and material change in the geographic location of the workplace at which the Covered Executive must perform services; or

(D) any other action or inaction that constitutes a material breach by the Employer or a successor of the agreement under which the Covered Executive provides services.

In the case of (B) above, such reduction will not constitute good reason if it results from a general across-the-board reduction for executives at a similar job level within the Employer.

(ii) In the case of a voluntary termination of employment by a Covered Executive upon or within two (2) years following a Change of Control:

(A) a material downward change in job functions, duties, or responsibilities which reduces the rank or position of the Covered Executive;

(B) a reduction in the Covered Executive’s annual base salary;

(C) a reduction in the aggregate value of the Covered Executive’s annual base salary and annual incentive plan target bonus opportunity;

(D) a material reduction in the Covered Executive’s retirement or supplemental retirement benefits;

(E) an involuntary and material change in the geographic location of the workplace at which the Covered Executive must perform services; or

(F) any other action or inaction that constitutes a material breach by the Employer or a successor of the agreement under which the Covered Executive provides services.

During this period, no adverse change may be made to a Covered Executive's (1) Base Salary, (2) Base Salary and annual incentive plan target bonus opportunity in the aggregate, or (3) retirement or supplemental retirement benefits.

For avoidance of doubt, if the Covered Executive holds the title of Chief Executive Officer immediately before the occurrence of a Change of Control, in the event of the occurrence of a Change of Control in which the Covered Executive retains the same position with the Company, and any of the following events occur on or within two (2) years after the date of the Change of Control, such new role shall be treated as a "material downward change in job functions, duties or responsibilities" within the meaning of Section 2.1(x)(ii)(A) above:

(1) Covered Executive ceases to be a member of the Board (or if the Company becomes directly or indirectly controlled by Parent, Covered Executive does not become a member of the Board of Directors of Parent);

(2) the Company either (A) ceases to have a class of equity securities that is actively traded on a national securities exchange or comparable public securities market or (B) becomes directly or indirectly controlled by Parent and the Covered Executive does not serve as the Chief Executive Officer of Parent; or

(3) Covered Executive is directed by the Board (or by Parent, if the Company becomes directly or indirectly controlled by Parent) to engage in an act or omission, which if performed would provide the Company with a basis for terminating Covered Executive for Cause.

(iii) If the Covered Executive believes that an event constituting Good Reason has occurred, in accordance with this Section 2.1(x)(i) or Section 2.1(x)(ii) above, as applicable, the Covered Executive must notify the Plan Administrator of that belief within ninety (90) days of the occurrence of the Good Reason event, which notice will set forth the basis for that belief. The Plan Administrator will have thirty (30) days after receipt of such notice (the " **Determination Period** ") in which to either rectify such event, determine that an event constituting Good Reason does not exist, or determine that an event constituting Good Reason exists. If the Plan Administrator does not take any of such actions within the Determination Period, the Covered Executive may terminate his employment with the Employer for Good Reason immediately at the end of the Determination Period by giving written notice to the Employer within ninety (90) days after the end of the Determination Period, which termination will be a Qualifying Termination effective on the date that such notice is received by the Employer, provided that such date constitutes the Covered Executive's "separation from service" within the meaning of section 409A of the Code. If the Plan Administrator

determines that Good Reason does not exist, then (A) the Covered Executive will not be entitled to rely on or assert such event as constituting Good Reason, and (B) the Covered Executive may file a claim pursuant to Article IV within thirty (30) days after the Covered Executive's receipt or written notice of the Plan Administrator's determination. A termination of employment for Good Reason will be treated as an involuntary termination for purposes of the ESP.

(y) " **Human Resources Committee** " means the Human Resources Committee of the Board, which has the authority to amend and terminate the ESP as provided in Article VI.

(z) " **Key Employee** " means any employee or former employee of the Employer (including any deceased employee) who at any time during the Plan Year was:

(i) an officer of the Company or an Affiliate having compensation of greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code for Plan Years beginning after December 31, 2002) (such limit is one hundred seventy five thousand dollars ($175,000) for 2018);

(ii) a Five Percent Owner; or

(iii) a One Percent Owner having compensation within the meaning of section 415(c) of the Code of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or One Percent Owner in accordance with section 1.415(c)-2(d)(4) of the Treasury Regulations (*i.e.* , W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections) under section 132(f) of the Code (regarding qualified transportation fringe benefits) or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special timing rules and special rules set forth, respectively, in sections 1.415(c)-2(e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (*i.e.* , the identification date). Employees that are Key Employees during such twelve (12) month period will be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (*i.e.* , since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder. For purposes of determining whether an employee or former employee is an officer, a Five Percent Owner or a One Percent Owner, the Company and each Affiliate will be treated as a separate employer (*i.e.* , the controlled group rules of sections 414(b),

(c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.1(z)(i), compensation from the Company and all Affiliates will be taken into account (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.1(z)(i), no more than fifty (50) employees of the Company or its Affiliates (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50), the determination of which employees or former Employees are officers will be determined based on who had the largest annual compensation from the Company and Affiliates for the Plan Year.

(aa) " **One Percent Owner** " means any person who would be described as a Five Percent Owner in Section 2.1(u) if "one percent (1%)" were substituted for "five percent (5%)" each place where it appears therein.

(bb) " **Parent** " means an entity that controls another entity directly, or indirectly through one or more intermediaries, and that itself is not a Subsidiary.

(cc) " **Plan Administrator** " means the individual or committee appointed by the RPAC to handle the day-to-day administration of the ESP. If the RPAC does not appoint an individual or committee to serve as the Plan Administrator, the RPAC will be the Plan Administrator.

(dd) " **Plan Year** " means the fiscal year of the ESP, which will commence on January 1 each year and end on December 31 of such year.

(ee) " **Potential Change of Control** " means the earliest to occur of:

(i) the Company enters into an agreement the consummation of which, or the approval by the stockholders of which, would constitute a Change of Control;

(ii) proxies for the election of members of the Board are solicited by any person other than the Company;

(iii) any person publicly announces an intention to take or to consider taking actions which, if consummated would constitute a Change of Control; or

(iv) any other event occurs which is deemed to be a potential change of control by the Board and the Board adopts a resolution to the effect that a Potential Change of Control has occurred.

(ff) " **Protection Period** " means the period beginning on the date that is six (6) months before the occurrence of a Change of Control and ending twenty-four (24) months after the occurrence of a Change of Control.

(gg) " **Qualifying Termination** " means the Covered Executive's "separation from service" (within the meaning of section 409A of the Code) by reason of:

(i) the involuntary termination of a Covered Executive's employment by the Employer without Cause, or

(ii) the Covered Executive's resignation from the employment of the Employer for Good Reason;

provided, however, that a Qualifying Termination will not occur by reason of the divestiture of an Affiliate with respect to a Covered Executive employed by such Affiliate who is offered a comparable position with the purchaser and either declines or accepts such position as provided in Section 6.4.

(hh) " **Reimbursement Period** " means the period of time commencing as of the date of the Covered Executive's Qualifying Termination and ending as of the close of the second taxable year of the Covered Executive that follows the taxable year in which such Qualifying Termination occurred.

(ii) " **RPAC** " means the Retirement Plans Administration Committee of the Company established by the Human Resources Committee and whose members have been appointed by the Human Resources Committee or a delegate thereof. The RPAC will have the responsibility to administer the ESP and make final determinations regarding claims for benefits, as described in Article IV.

(jj) " **SERP** " means the Tenet Healthcare Corporation Supplemental Executive Retirement Plan or any other supplemental executive retirement plan maintained by the Employer in which Covered Executives participate.

(kk) " **Severance Pay** " means, except as provided otherwise in the Covered Executive's ESP Agreement, as follows:

(i) For Covered Executives who entered into an ESP Agreement prior to the execution date for the Tenet Fourth Amended and Restated Executive Severance Plan, the sum of the Covered Executive's Base Salary and Target Bonus as of the date of a Qualifying Termination, and

(ii) For Covered Executives who entered into an ESP Agreement on or after the execution date for the Tenet Fourth Amended and Restated Executive Severance Plan, the sum of the Covered Executive's Base Salary and Average Bonus as of the date of a Qualifying Termination.

(ll) " **Severance Period** " means

(i) **Pre-November 6, 2013 Covered Executives.** For a Covered Executive who entered into an ESP Agreement before the execution date of the Tenet Third Amended and Restated Executive Severance Plan and except as provided otherwise in the Covered Executive's ESP Agreement or offer letter:

(A) the period specified in Section 3.1(a) of the Tenet Second Amended and Restated Executive Severance Plan with respect to Severance Pay payable on account of a Qualifying Termination not related to a Change of Control as set forth below, and

Covered Executive	Severance Period
Tenet CEO	Three (3) years
COO and CFO	Two and one-half (2.5) years
SVPs and EVPs	One and one-half (1.5) years
VPs and Hospital CEOs	One (1) year

(B) the period specified in Section 3.2(a) of the Tenet Second Amended and Restated Executive Severance Plan on account of a Qualifying Termination in connection with a Change of Control as set forth below:

Covered Executive	Severance Period
Tenet CEO	Three (3) years
COO and CFO	Three (3) years
SVPs and EVPs	Two (2) years
VPs and Hospital CEOs	One and one-half (1.5) years

(ii) **Post-November 6, 2013 and Vanguard Covered Executives.** For a Covered Executive who entered into an ESP Agreement on and after the execution date for the Tenet Third Amended and Restated Executive Severance Plan, and for a Covered Executive employed by Vanguard Health System Inc. or its Controlled Group Members regardless of when first employed, the periods specified in the Covered Executive's ESP Agreement or if no such periods are specified the periods specified in Section 2.1(ll)(i)(A) and Section 2.1(ll)(B) above, as applicable, based on the position of the Covered Executive as determined by the Plan Administrator or Senior Vice President, Human Resources. As required by section 409A of the Code, any Severance Period specified in the Covered Executive's ESP Agreement will be the same for a Qualifying Termination occurring outside of the Protection Period and a Qualifying Termination occurring during that portion of the Protection Period that precedes a Change of Control described in Section 2.1(h)(iv). A different Severance Period may apply for a Qualifying Termination that occurs at any time during the Protection Period with respect a Change of Control described in Section 2.1(h)(i), Section 2.1(h)(ii) or Section 2.1(h)(iii) or during that portion of the Protection Period that occurs on or after a Change of Control described in Section 2.1(h)(iv).

(mm) " **SIP** " means the Third Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan or the Tenet Healthcare 2008 Stock Incentive Plan or any successor to such plans.

(nn) " **Subsidiary** " means an entity controlled by another entity directly, or indirectly through one or more intermediaries.

(oo) " **Target Bonus** " means the target bonus percent applicable to the Covered Executive under the AIP multiplied by his Base Salary at the time of a Qualifying Termination. For example, if the Covered Executive earns one hundred and fifty

thousand dollars ($150,000) and has a target bonus percent of fifty percent (50%), his Target Bonus equals seventy-five thousand dollars ($75,000).

(pp) " **TESPP** " means the ESP in effect immediately before May 11, 2006.

2.2 Construction. If any provision of the ESP is determined to be for any reason invalid or unenforceable, the remaining provisions of the ESP will continue in full force and effect. All of the provisions of the ESP will be construed and enforced in accordance with the laws of the State of Texas and will be administered according to the laws of such state, except as otherwise required by ERISA, the Code or other applicable federal law. When delivery to the RPAC, Plan Administrator or the Covered Executive is required under this ESP, such delivery requirement will be satisfied by delivery to a person or persons designated by the RPAC, Plan Administrator or the Covered Executive, as applicable. Delivery will be deemed to have occurred only when the form or other communication is actually received. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of the ESP. The pronouns "he," "him" and "his" used in the ESP will also refer to similar pronouns of the female gender unless otherwise qualified by the context.

2.3 409A Compliance. The ESP is intended to comply with the requirements of section 409A of the Code. The provisions of the ESP will be construed and administered in a manner that enables the ESP to comply with the provisions of section 409A of the Code.

End of Article II

ARTICLE III
SEVERANCE BENEFITS

3.1 Severance Benefits Not Related to a Change of Control. Except as provided otherwise in a Covered Executive's ESP Agreement, a Covered Executive who incurs a Qualifying Termination occurring outside of the Protection Period, subject to the limitations contained in the ESP, will receive the following severance benefits.

(a) **Severance Period** . The Covered Executive will be entitled to the payment of Severance Pay over the Severance Period as specified in Section 2.1(ll)(i)(A) or (ii), as applicable.

Such Severance Pay will be paid on a bi-weekly basis commencing as of the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period, subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (i.e., the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed). All distributions from the ESP will be taxable as ordinary income when received and subject to appropriate withholding of income taxes and reported on Form W-2. Except as otherwise provided herein, a Covered Executive who incurs a Qualifying Termination will have formally terminated his employment relationship with the Employer as of the date of such Qualifying Termination and will not be deemed to be an Employee at any time during the Severance Period or thereafter.

(b) **Other Accrued Obligations** . The Covered Executive will be entitled to payment of all accrued Base Salary, accrued time off and any other accrued and unpaid obligations as of the date of the Qualifying Termination. Such accrued obligations will be included and paid as part of the Covered Executive's final paycheck from the Employer.

(c) **Bonus** . The Covered Executive will be entitled to payment of the Bonus earned in accordance with the terms of the AIP as acted on by the Human Resources Committee during the calendar year of the Qualifying Termination. Such Bonus will be prorated as a fraction of twelve (12) for full months worked by the Covered Executive for the Employer or an Affiliate during such calendar year and will be paid to the Covered Executive, at the time and in the same manner specified in the AIP.

(d) **Continued Welfare Benefits** . During the Severance Period, the Covered Executive and his dependents will be entitled to continue to participate in any medical, dental, vision, life and long-term care benefit programs maintained by the Employer in which such persons were participating immediately before the date of the Qualifying Termination; provided, that the continued participation of such persons is possible under the general terms and provisions of such benefit programs. If such continued participation is barred, then the Employer will arrange to provide such persons with substantially similar coverage to that which such persons would have otherwise been entitled to receive under such benefit programs from which such continued participation is barred. In either case, however, the Covered Executive will be

required to continue to pay, on a pre-tax or after-tax basis, as applicable, his portion of the cost of such coverages as in effect at the time of the Qualifying Termination, and the Employer will continue to pay its portion of such costs, as in effect at the time of the Qualifying Termination. Any coverage provided pursuant to this Section 3.1(d) will be limited and reduced to the extent equivalent coverage is otherwise provided by (or available from or under) any other employer of the Covered Executive. The Covered Executive must advise the Plan Administrator of the attainment of any such subsequent employer benefit coverages within thirty (30) days following such attainment.

The pre-tax or after-tax payroll deductions for the continued medical, dental, vision life and long-term care benefits described above will be taken from the Covered Executive's Severance Pay pursuant to the Employer's normal payroll practices; provided, however, that if any of such coverages are provided on a self-insured basis, the Covered Executive will be required to pay his portion of the cost of such coverages on an after-tax basis and the remainder of such cost will be included in the Covered Executive's income and reported as wages on Form W-2. Any continued medical, dental or vision benefits provided to the Covered Executive and his dependents pursuant to this Section 3.1(d) is in addition to any rights the Covered Executive and such dependents may have to continue such coverages under COBRA. The provisions of this Section 3.1(d) will not prohibit the Company from changing the terms of such medical, dental, life vision or long-term care benefit programs provided that any such changes apply to all executives of the Company and its Affiliates (e.g., the Company may switch insurance carriers or preferred provider organizations).

(e) **Outplacement Services** . The Covered Executive will be entitled to reimbursement of any expenses reasonably incurred by him for outplacement services in an amount equal to the lesser of ten percent (10%) of his Base Salary or twenty-five thousand dollars ($25,000). In order to comply with the exemption applicable to post-separation reimbursement plans under section 409A of the Code: (i) the reimbursement of such expenses for outplacement services only will be permitted with respect to expenses that are incurred during the shorter of the Severance Period or the Reimbursement Period and (ii) any reimbursement of such expenses that are incurred during a particular taxable year of the Covered Executive must be made by the last day of the Covered Executive’s immediately following taxable year.

(f) **Payment of Legal Expenses** . The Covered Executive will be entitled to reimbursement of any legal expenses reasonably incurred by him in order to obtain benefits under the ESP; provided, that, the payment of such expenses is subject to an arms-length, bona fide dispute as to the Covered Executive's right to such benefits. In order to comply with the exemption applicable to post-separation reimbursement plans under section 409A of the Code, in the event such legal expenses are otherwise deductible under section 162 or 167 of the Code (without regard to any limitation on the Covered Executive’s adjusted gross income): (i) the reimbursement of such legal expenses only will be permitted with respect to expenses that are incurred during the shorter of the Severance Period or the Reimbursement Period; and (ii) any reimbursement of such legal expenses that are incurred during a particular taxable year of the Covered Executive must be made

by the last day of the Covered Executive's immediately following taxable year. In the event that the legal expenses are not otherwise deductible under section 162 or 167 or the Code (without regard to any limitation on the Covered Executive's adjusted gross income), then in order to comply with the expense reimbursement provisions of section 409A of the Code, the reimbursement of such expenses will be made pursuant to the terms of Section 3.1(f)(i) and Section 3.1(f)(ii) above; provided, that the amount of legal expenses reimbursed or eligible for reimbursement during a taxable year of the Covered Executive that occurs during the Severance Period or Reimbursement Period will not affect the legal expenses that are eligible for reimbursement in any other taxable year of the Covered Executive that occurs during the Severance Period or Reimbursement Period and that such legal expense reimbursement amounts will be subject to the six (6) month delay (when applicable) for distributions in excess of the 409A Exempt Amount as set forth in Section 3.3.

(g) **Equity Compensation Adjustments** . Except as provided otherwise in the Covered Executive's ESP Agreement, upon a Qualifying Termination, any equity-based compensation awards granted to the Covered Executive by the Employer under the SIP or an Equity Plan before such termination that are outstanding and vested as of the date of the Qualifying Termination will be exercisable or settled pursuant to the terms of the SIP or the Equity Plan, as applicable. All unvested equity-based compensation awards held by the Covered Executive as of the date of the Qualifying Termination will expire and be of no effect, except to the extent that the terms of such awards provide for continued vesting and/or acceleration. With respect to performance cash awards, upon a Qualifying Termination, a Covered Executive will be entitled to "banked" amounts for past plan years and a pro-rated amount for performance in the year in which the Qualifying Termination occurs, in accordance with the terms of such awards. No Covered Executive will be entitled to any new equity-based compensation awards following the date of his Qualifying Termination or during the Severance Period.

(h) **SERP** . A Covered Executive who is also a participant in the SERP and became such a participant before August 3, 2011 will be entitled to age and service credit for the duration of the Severance Period under the SERP. A Covered Executive who is also a participant in the SERP but became such a participant on or after August 3, 2011 will not be entitled to age and service credit for the duration of the Severance Period under the SERP. Benefits under the SERP will be payable to the Covered Executive pursuant to the terms of the SERP; provided, however, that if the Covered Executive is entitled to commence SERP benefits during the Severance Period pursuant to the terms of the SERP; the amount of Severance Pay payable to Executive pursuant to the ESP will be offset (i.e., reduced) by the amount of the SERP benefits payable during the Severance Period. With respect to a Covered Executive who became a SERP participant before August 3, 2011, for purposes of determining the amount of the Covered Executive's SERP benefits, any actuarial reduction that would otherwise apply under the SERP due to the commencement of SERP benefits during the Severance Period will be disregarded (i.e., the SERP benefits will only be actuarially reduced for early commencement beginning with the last day of the Severance Period). Further, while the age credit will accrue throughout the course of the Severance Period, at the end of the

Severance Period, the Covered Executive's SERP benefits will be recalculated to take into account the additional service credit provided under the ESP during the Severance Period. With respect to a Covered Executive who became a SERP participant on or after August 3, 2011, for purposes of determining the amount of the Covered Executive's SERP benefits, the actuarial reduction will be determined under the terms of the SERP as of the date of the Covered Executive's Qualifying Termination. A Covered Executive's Severance Pay will not be considered in calculating the Covered Executive's "Final Average Earnings" under the SERP. Notwithstanding the foregoing, in no event will any provision in this Section 3.1(h) be construed to permit the distribution of any SERP benefits during the six (6) month restriction period, as described in the SERP, which follows a Key Employee's Qualifying Termination.

(i) **DCP** . The Covered Executive will incur a termination of employment for purposes of the DCP at the time of a Qualifying Termination and accordingly will not be entitled to defer any portion of his Severance Pay to the DCP during the Severance Period. The Covered Executive's DCP benefits will be paid to him pursuant to the terms of the DCP and the Covered Executive's distribution election under the DCP in a manner that complies with section 409A of the Code.

(j) **401(k)** . The Covered Executive will incur a severance from employment for purposes of the 401(k) Plan on the date of the Qualifying Termination and accordingly will not be entitled to defer any portion of his Severance Pay to the 401(k) Plan during the Severance Period. The Covered Executive's 401(k) Plan benefits will be payable to him under the 401(k) Plan pursuant to the terms of the 401(k) Plan.

3.2 Severance Benefits on and after a Change of Control. Except as provided otherwise in a Covered Executive's ESP Agreement, a Covered Executive who incurs a Qualifying Termination during the Protection Period with respect to a Change of Control will, subject to the limitations contained in the ESP, receive the severance benefits described in Section 3.1, (provided, however, that a Covered Executive will only receive the additional age and service credit as set forth in Section 3.1(h) herein in accordance with the terms and provisions of the SERP), plus the additional severance benefits, if any, provided in this Section 3.2. Further, within five (5) business days following the occurrence of a Change of Control, the Company must contribute to a domestic rabbi trust an amount sufficient to fully fund the severance benefits accrued as of the date of the Change of Control pursuant to this Section 3.2. Such funding obligation will continue for each calendar quarter during the twenty-four (24) month period following such Change of Control, with such funding to be made within five (5) business days following the end of each such calendar quarter.

(a) **Severance Period** . The Covered Executive will be entitled to the payment of Severance Pay for the Severance Period as specified in Section 2.1(ll)(i)(B) or (ii), as applicable.

(b) **Payment of Severance Pay** . In the event that a Covered Executive's Qualifying Termination occurs during the portion of the Protection Period that precedes any Change of Control described in Section 2.1(h)(i), Section 2.1(h)(ii) or Section 2.1(h)(iii), the Covered Executive will receive Severance Pay that will be paid on a bi-weekly basis commencing on the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period

subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (*i.e.* , the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed). To the extent that such Change of Control is described in Section 2.1(h)(iv), such Severance Pay in excess of the 409A Exempt Amount will be paid on a bi-weekly basis commencing on the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period specified in Section 3.1(a) subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (*i.e.* , the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed).

In the event that a Covered Executive's Qualifying Termination occurs during the portion of the Protection Period that occurs on or after a Change of Control described in Section 2.1(h)(i), Section 2.1(h)(ii) or Section 2.1(h)(iii), the Covered Executive will receive, subject to the six (6) month delay for distributions in excess of the 409A Exempt Amount as set forth in Section 3.3, a lump sum payment of Severance Pay, in the amount determined pursuant to Section 3.2(a), within ninety (90) days following such Qualifying Termination. To the extent that such Change of Control is described in Section 2.1(h)(iv), such Severance Pay in excess of the 409A Exempt Amount will be paid on a bi-weekly basis commencing on the date of the Qualifying Termination pursuant to the Employer's ordinary payroll schedule for the duration of the Severance Period subject to the six (6) month delay applicable to Key Employees described in Section 3.3 (*i.e.* , the payment of Severance Pay in excess of the 409A Exempt Amount that would otherwise be payable to a Key Employee during the six (6) month period following the Qualifying Termination will be delayed).

The payment provisions of this Section 3.2(b) are summarized below.

Change of Control Event	Qualifying Termination During Protection Period Occurring Before Change of Control	Qualifying Termination During Protection Period Occurring on and After a Change Of Control
Section 2.1(h)(i) - change in stock ownership	● Bi-weekly payment of Severance Pay over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay) paid in Lump sum subject to six (6) month delay
Section 2.1(h)(ii) - change in effective control	● Bi-weekly payment of Severance over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay paid in Lump sum subject to six (6) month delay
Section 2.1(h)(iii) - sale of assets	● Bi-weekly payment of Severance Pay over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay paid in Lump sum subject to six (6) month delay
Section 2.1(h)(iv) - liquidation or dissolution	● Bi-weekly payment of Severance Pay over Severance Period ● Amounts in excess of 409A Exempt Amount subject to six (6) month delay	● Lump sum payment of 409A Exempt Amount ● Remainder of Severance Pay paid bi-weekly over Severance Period subject to six (6) month delay

(c) **Equity Compensation Adjustments** .

(i) Except as provided otherwise in the Covered Executive's ESP Agreement, in the event of a Change of Control, if the successor to the Company does not assume the SIP or the applicable Equity Plan or grant comparable awards in substitution of the outstanding awards under the SIP or applicable Equity Plan as of the date of the Change of Control, then any equity-based compensation awards granted to the Covered Executive by the Employer under the SIP or Equity Plan and outstanding as of the date of the Change of Control will become immediately fully vested and/or exercisable and will no longer be subject to a substantial risk of forfeiture or restrictions on transferability, other than those imposed by applicable legislative or regulatory requirements. With respect to performance cash awards, however, in the event the successor to the Company does not assume the awards, the awards will become payable at earned levels for completed plan years and at target performance levels for the year in which the Change of Control occurs and future plan years, as applicable, payable in accordance with the terms of such awards, and if not addressed in an award agreement, then payable on the date of the Change of Control.

(ii) Except as provided otherwise in the Covered Executive's ESP Agreement, if the successor to the Company assumes the SIP or the applicable Equity

Plan or substitutes the awards under the SIP or applicable Equity Plan with comparable awards; then any equity-based compensation awards granted to the Covered Executive by the Employer under the SIP or Equity Plan before such termination and outstanding as of the date of the Change of Control or any substituted awards given with respect to such outstanding awards will continue to be maintained pursuant to their terms; provided, however, that upon a Covered Executive's Qualifying Termination during the Protection Period in connection with such Change of Control, any such equity compensation awards outstanding as of the date of the Qualifying Termination will become immediately vested and/or exercisable, in accordance with the terms of such awards, except as set forth below in this paragraph, on the date of the Qualifying Termination or, if the Qualifying Termination occurs during the portion of the Protection Period that precedes the Change of Control, then on the date of the Change of Control, and will no longer be subject to a substantial risk of forfeiture or restrictions on transferability, other than those imposed by applicable legislative or regulatory requirements. With respect to performance cash awards, however, upon a Qualifying Termination during the Protection Period in connection with such Change of Control, a Covered Executive will be paid earned amounts for completed plan years and target amounts for the year in which the Qualifying Termination occurs and future plan years, as applicable, payable on the scheduled payment date. Furthermore, with respect to performance-based restricted stock units and performance options, upon a Qualifying Termination during the Protection Period in connection with such Change of Control, accelerated vesting is only provided to the extent that the applicable performance criteria are achieved (with pro rata vesting based on service during the performance period if the termination occurs during the performance period). No Covered Executive will be entitled to any new equity-based compensation awards following the date of his Qualifying Termination or during the Severance Period.

(d) **Parachute Limitation** .

(i) If at any time or from time to time, it shall be determined by an independent nationally known financial accounting or law firm experienced in such matters selected by the Company (" **Tax Professional** ") that any payment or other benefit to the Covered Executive pursuant to the ESP or otherwise (" **Potential Parachute Payment** ") is or will, but for the provisions of this Section 3.2(d), become subject to the excise tax imposed by section 4999 of the Code or any similar tax payable under any state, local, foreign or other law, but expressly excluding any income taxes and penalties or interest imposed pursuant to section 409A of the Code (" **Excise Taxes** "), then the Covered Executive’s Potential Parachute Payment will be either (A) provided to the Covered Executive in full, or (B) provided to the Covered Executive as to such lesser extent which would result in no portion of such benefits being subject to the Excise Taxes, whichever of the foregoing amounts, when taking into account applicable federal, state, local and foreign income and employment taxes, the Excise Tax, and any other applicable taxes, results in the receipt by the Covered Executive, on an after-tax basis, of the greatest

amount of benefits, notwithstanding that all or some portion of such benefits may be taxable under the Excise Taxes (" **Payments** ").

(ii) In the event of a reduction of benefits pursuant to Section 3.2(d)(i), the Tax Professional will determine which benefits will be reduced so as to achieve the principle set forth in Section 3.2(d)(i). For purposes of making the calculations required by Section 3.2(d)(i), the Tax Professional may make reasonable assumptions and approximations concerning applicable taxes and may rely on reasonable, good faith interpretations concerning the application of the Code and other applicable legal authority. The Company and the Covered Executive will furnish to the Tax Professional such information and documents as the Tax Professional may reasonably request in order to make a determination under Section 3.2(d)(i). The Company will bear all costs the Tax Professional may reasonably incur in connection with any calculations contemplated by Section 3.2(d)(i).

(iii) If, notwithstanding any calculations performed or reduction in benefits imposed as described in Section 3.2(d)(i), the IRS determines that the Covered Executive is liable for Excise Taxes as a result of the receipt of any payments made pursuant to this ESP or otherwise, then the Covered Executive will be obligated to pay back to the Company, within thirty (30) days after a final IRS determination or in the event that the Covered Executive challenges the final IRS determination, a final judicial determination, a portion of the Payments equal to the "Repayment Amount." The Repayment Amount will be the smallest such amount, if any, as will be required to be paid to the Company so that the Covered Executive's net after-tax proceeds with respect to the Payments (after taking into account the payment of the Excise Taxes and all other applicable taxes imposed on such benefits) are maximized. The Repayment Amount will be zero if a Repayment Amount of more than zero would not result in the Covered Executive's net after-tax proceeds with respect to the Payments being maximized. If the Excise Taxes are not eliminated pursuant to this Section 3.2(d)(iii), the Covered Executive will pay the Excise Taxes.

(iv) Notwithstanding any other provision of this Section 3.2(d), if (A) there is a reduction in the payments to a Covered Executive as described above in this Section 3.2(d), (B) the IRS later determines that the Covered Executive is liable for Excise Taxes, the payment of which would result in the maximization of the Covered Executive's net after-tax proceeds (calculated based on the full amount of the Potential Parachute Payment and as if the Covered Executive's benefits had not previously been reduced), and (C) the Covered Executive pays the Excise Tax, then the Company will pay to the Covered Executive those payments which were reduced pursuant to Section 3.2(d)(i) or 3.2(d)(iii) as soon as administratively possible after the Covered Executive pays the Excise Taxes to the extent that the Covered Executive's net after-tax proceeds with respect to the payment of the Payments are maximized.

(e) **Non-Compete** . At the discretion of the Employer, a Covered Executive will be entitled to enter into a non-compete agreement whereby the Covered Executive will be precluded from competing with the Employer following a Qualifying Termination that occurs during the Severance Period or such other period as may be set forth in a written agreement in consideration for a cash payment in an amount as determined at the discretion of the Employer. Such non-compete will be evidenced by a written agreement signed by the Employer and the Covered Executive. In the event that a Covered Executive enters into a non-compete agreement as described in this Section 3.2(e) and any provisions therein conflict with any of the provisions as set forth in this ESP, the provisions of the non-compete agreement will control.

3.3 Termination Distributions to Key Employees. A portion of the distributions under the ESP that are payable to a Covered Executive who is a Key Employee on account of a Qualifying Termination will be delayed for a period of six (6) months following such Covered Executive's Qualifying Termination to the extent such distributions under the ESP exceed the 409A Exempt Amount. Upon the expiration of such six (6) month period, amounts that would have been paid to the Covered Executive during such six (6) month period, will be paid to him on the first business day following the close of such period in the form of a lump sum payment and the remaining amounts payable to the Covered Executive under the ESP will be paid with respect to the remainder of the Severance Period pursuant to the terms of this Article III (*e.g.* , Severance Pay will be paid on a bi-weekly basis for the remainder of the Severance Period in the case of (i) Severance Pay that is not payable on account of a Change in Control, (ii) Severance Pay that is payable on account of a Qualifying Termination during the portion of the Protection Period that precedes a Change in Control described in Section 2(g), and (iii) Severance Pay that is payable on account of a Qualifying Termination during the portion of the Protection Period that occurs on and after a Change of Control described in Section 2.1(h)(iv)). This six (6) month restriction will not apply, or will cease to apply, with respect to distributions by reason of the death of the Covered Executive pursuant to Section 3.4.

3.4 Distributions on Account of Death of the Covered Executive During the Severance Period. Except as provided otherwise in the Covered Executive's ESP Agreement, if a Covered Executive dies during the Severance Period the following benefits will be payable:

(a) **Severance Pay** . Any remaining Severance Pay payable to the Covered Executive as of the date of his death will continue to be paid to the Covered Executive's estate pursuant to Section 3.1(a) or 3.2(a), as applicable.

(b) **Other Accrued Obligations** . Any unpaid Base Salary, time off and any other accrued and unpaid obligations that remain outstanding as of the date of the Covered Executive's death will be paid to the Covered Executive's estate pursuant to Section 3.1(b).

(c) **Bonus** . Any unpaid Bonus described under Section 3.1(c) that remains outstanding as of the date of the Covered Executive's death will be paid to the Covered Executive’s estate pursuant to Section 3.1(c).

(d) **Continued Welfare Benefits** . The Covered Executive's dependents will be entitled to continue to participate in any medical, dental, vision, life and long-term care benefit programs maintained by the Employer in which such persons were

participating immediately before the date of the Covered Executive's death for the remainder of the Severance Period, subject to the provisions of Section 3.1(d). At the end of the Severance Period such dependents will be eligible to elect to continue their medical, dental or vision coverage pursuant to COBRA.

(e) **Outplacement Services** . Any outplacement service benefits payable to the Covered Executive pursuant to Section 3.1(e) will cease as of the date of the Covered Executive's death; provided, that any eligible outplacement expenses incurred before the Covered Executive's death will be reimbursable to the Covered Executive's estate pursuant to Section 3.1(e).

(f) **Payment of Legal Expenses** . The obligation to reimburse the Covered Executive for any legal fees will continue pursuant to the terms of the ESP following his death, except that such legal fees or excise tax reimbursement will be payable to the Covered Executive's estate.

(g) **Equity Compensation Adjustments** . Any outstanding equity-based compensation awards granted to the Covered Executive that are outstanding as of the date of the Covered Executive’s death will be exercisable or settled pursuant to the terms of the SIP or the Equity Plan, as applicable.

3.5 Section 409A Gross-Up Payment. In the event that a Covered Executive (or his estate) pays the excise taxes and any other interest and penalty payments (as applicable) pursuant to section 409A of the Code (" **409A Excise Tax** ") with respect to the benefits payable under the ESP, the Covered Executive (or his estate) will be entitled to a reimbursement equal to the amount of any 409A Excise Tax paid by the Covered Executive (or his estate) pursuant to section 409A of the Code. The Company will provide a reimbursement to the Covered Executive with respect to any payment of the 409A Excise Tax (or portion thereof) no later than the close of the Covered Executive's taxable year that immediately follows the taxable year in which such payment is made. If the Covered Executive is a Key Employee, payment of the amounts described in this Section 3.5 will be subject to a six (6) month delay (when applicable) for distributions in excess of the 409A Exempt Amount as provided in Section 3.3.

3.6 Alternate Plan Terms. Subject to the requirements of section 409A of the Code, the Senior Vice President, Human Resources and/or Plan Administrator (or before the Effective Date the Human Resources Committee) reserve the right to modify the terms of this ESP with respect to any Covered Executive (*e.g.* , to provide different benefits than those set forth herein). Such modified terms will be set forth in the Covered Executive's ESP Agreement or in such other form as may be determined by the Senior Vice President, Human Resources and/or Plan Administrator (or before the Effective Date the Human Resources Committee), each in its sole and absolute discretion.

3.7 Conditions to Payment of Severance Benefits. As a condition of obtaining benefits under the ESP, the Covered Executive will be required to execute a Severance Agreement and General Release. Such Severance Agreement and General Release will contain the restrictive covenants set forth below regarding non-competition, confidentiality, non-disparagement and non-solicitation as well as a general release of claims against the Company and its Affiliates.

(a) **Non-Competition** . Payment of any and all severance benefits provided under the ESP will cease if, at any time during the Severance Period described in Section

3.1(a), the Covered Executive directly or indirectly, carries on or conducts, in competition with the Company and its Affiliates, any business of the nature in which the Company or its Affiliates are then engaged in any geographical area in which the Company or its Affiliates engage in business at the time of the Covered Executive's Qualifying Termination or in which any of them, before such Qualifying Termination, evidenced in writing, at any time during the six (6) month period before such termination, an intention to engage in such business. This prohibition extends to the Covered Executive's conducting or engaging in any such business either as an individual on his own account or as a partner or joint venturer or as an executive, agent, consultant or salesman for any other person or entity, or as an officer or director of a corporation or as a shareholder in a corporation of which he will then own ten percent (10%) or more of any class of stock. The provisions of this Section 3.7(a) will not apply with respect to severance benefits payable pursuant to Section 3.2(a).

(b) **Confidential Information** . Payment of any and all severance benefits will cease if, at any time during the Severance Period described in either Section 3.1(a) of 3.2(a), the Covered Executive directly or indirectly reveals, divulges or makes known to any person or entity, or uses for the Covered Executive's personal benefit (including without limitation for the purpose of soliciting business, whether or not competitive with any business of the Company or any of its Affiliates), any information acquired during the Covered Executive's employment with the Company or its Affiliates with regard to the financial, business or other affairs of the Company or any of its Affiliates (including without limitation any list or record of persons or entities with which the Company or any of its Affiliates has any dealings), other than:

(i) information already in the public domain,

(ii) information of a type not considered confidential by persons engaged in the same business or a business similar to that conducted by the Company or its Affiliates, or

(iii) information that the Covered Executive is required to disclose under the following circumstances:

(A) at the express direction of any authorized governmental entity;

(B) pursuant to a subpoena or other court process;

(C) as otherwise required by law or the rules, regulations, or orders of any applicable regulatory body; or

(D) as otherwise necessary, in the opinion of counsel for the Covered Executive, to be disclosed by the Covered Executive in connection with any legal action or proceeding involving the Covered Executive and the Company or any Affiliate in his capacity as an employee, officer, director, or stockholder of the Company or any Affiliate.

The Covered Executive will, at any time requested by the Company (either during his employment with the Company and its Affiliates or during the Severance Period), promptly deliver to the Company all memoranda, notes, reports, lists and other documents (and all copies thereof) relating to the business of the Company or any of its Affiliates which he may then possess or have under his control.

(c) **Agreement Not To Solicit Employees** . Payment of any and all severance benefits will cease if, at any time during the Severance Period the Covered Executive directly or indirectly solicits or induces, or in any manner attempts to solicit or induce, any person employed by, or any agent of, the Company or any of its Affiliates to terminate such employee's employment or agency, as the case may be, with the Company or any Affiliate.

(d) **Nondisparagement** . Payment of any and all severance benefits will cease if, at any time during the Severance Period the Covered Executive disparages the Company or its Affiliates and their respective boards of directors or other governing body, executives, employees and products or services. The Company will not disparage the Covered Executive during the Covered Executive's period of employment with the Company and its Affiliates or thereafter. For purposes of this Section 3.7(d), disparagement does not include:

(i) compliance with legal process or subpoenas to the extent only truthful statements are rendered in such compliance attempt,

(ii) statements in response to an inquiry from a court or regulatory body, or

(iii) statements or comments in rebuttal of media stories or alleged media stories.

(e) **409A Compliance** . If any payment made under the ESP (i) is subject to the execution of an effective release of claims, (ii) "provides for the deferral of compensation" within the meaning of section 409A of the Code and is not otherwise exempt from the application of section 409A of the Code, and (iii) could be made in either one of two consecutive taxable years on account of the requirement of the execution of an effective release of claims, then such payment will be made in the later taxable year.

The violation of this Section 3.7 by Covered Executive will entitle the Company to complete relief from such violation including, but not limited to, injunctive relief and damages as determined by an arbitrator, the cessation of severance benefits and a return of all severance benefits paid to the Covered Executive pursuant to the terms of the ESP. Such relief will apply regardless of whether such violation is discovered after the expiration of the Severance Period. The violation of Section 3.7(d) by the Company will entitle the Covered Executive to complete relief from such violation including, but not limited to, injunctive relief and damages as determined by an arbitrator.

3.8 Impact of Reemployment on Benefits

If a Participant incurs a Qualifying Termination and begins receiving Severance Pay from the ESP and such Participant is reemployed by the Employer or an Affiliate, then such Participant's Severance Pay will continue as scheduled during the period of his reemployment.

End of Article III

ARTICLE IV
ADMINISTRATION

4.1 The RPAC. The overall administration of the ESP will be the responsibility of the RPAC.

4.2 Powers of RPAC. The RPAC will have sole and absolute discretion regarding the exercise of its powers and duties under the ESP. In order to effectuate the purposes of the ESP, the RPAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the ESP;

(c) To construe the ESP and to make equitable adjustments for any mistakes or errors made in the administration of the ESP; and

(d) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the ESP and any trust established to secure the assets of the ESP:

(i) when differences of opinion arise between the Company, an Affiliate, the Plan Administrator, the trustee, a Covered Executive, or any of them, and

(ii) whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the ESP for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the RPAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the ESP.

4.3 Appointment of Plan Administrator. The RPAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the ESP on a daily basis. The RPAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the RPAC.

4.4 Duties of Plan Administrator. The Plan Administrator will have sole and absolute discretion regarding the exercise of its powers and duties under the ESP. The Plan Administrator will have the following powers and duties:

(a) To enter into, on behalf of the Employer, an ESP Agreement with an Employee who is deemed a Covered Executive pursuant to Section 2.1(l);

(b) To direct the administration of the ESP in accordance with the provisions herein set forth;

(c) To adopt rules of procedure and regulations necessary for the administration of the ESP, provided such rules are not in consistent with the terms of the ESP;

(d) To determine all questions with regard to rights of Covered Executives and beneficiaries under the ESP including, but not limited to, questions involving eligibility of an Employee to participate in the ESP and the level of a Covered Executive's benefits;

(e) to make all final determinations and computations concerning the benefits to which the Covered Executive or his estate is entitled under the ESP;

(f) To enforce the terms of the ESP and any rules and regulations adopted by the RPAC;

(g) To review and render decisions respecting a claim for a benefit under the ESP;

(h) To furnish the Employer with information that the Employer may require for tax or other purposes;

(i) To engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(j) To prescribe procedures to be followed by Covered Executives in obtaining benefits;

(k) To receive from the Employer and from Covered Executives such information as is necessary for the proper administration of the ESP;

(l) To create and maintain such records and forms as are required for the efficient administration of the ESP;

(m) To make all initial determinations and computations concerning the benefits to which any Covered Executive is entitled under the ESP;

(n) To give the trustee of any trust established to serve as a source of funds under the ESP specific directions in writing with respect to:

(i) making distribution payments, giving the names of the payees, specifying the amounts to be paid and the time or times when payments will be made; and

(ii) making any other payments which the trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator;

(o) To comply with all applicable lawful reporting and disclosure requirements of ERISA;

(p) To comply (or transfer responsibility for compliance to the trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(q) To construe the ESP, in its sole and absolute discretion, and make equitable adjustments for any errors made in the administration of the ESP.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other

duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the ESP.

4.5 Indemnification of RPAC and Plan Administrator. To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations, the Employer agrees to hold harmless and indemnify the RPAC and Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising out of any act or omission relating to or in connection with the ESP other than losses resulting from the RPAC's, or any such person's commission of fraud or willful misconduct.

4.6 Claims for Benefits.

(a) **Initial Claim** . In the event that a Covered Executive or his estate claims (a " **claimant** ") to be eligible for benefits, or claims any rights under the ESP or seeks to challenge the validity or terms of the Severance Agreement and General Release described in Section 3.5, such claimant must complete and submit such claim forms and supporting documentation as will be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any claimant who feels unfairly treated as a result of the administration of the ESP must file a written claim, setting forth the basis of the claim, with the Plan Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the claimant may examine the ESP, and any other pertinent documents generally available to Covered Executives that are specifically related to the claim.

A written notice of the disposition of any such claim will be furnished to the claimant within ninety (90) days after the claim is filed with the Plan Administrator. Such notice will refer, if appropriate, to pertinent provisions of the ESP, will set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of the ESP) and, where appropriate, will describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the claimant will also be notified of the ESP's claim review procedure and the time limits applicable to such procedure, including the claimant's right to arbitration following an adverse benefit determination on review as provided below. All benefits provided in the ESP as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review** . Within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant may file with the RPAC a written request for review of his claim. In connection with the request for review, the claimant will be entitled to be represented by counsel and will be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the claimant does not file a written request for review within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant will be deemed to have accepted the Plan Administrator's written disposition, unless the claimant was physically or mentally incapacitated so as to be unable to request review within the ninety (90) day period.

(c) **Decision on Review** . After receipt by the RPAC of a written application for review of his claim, the RPAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The RPAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address.

A decision on review of the claim will be made by the RPAC at its next meeting following receipt of the written request for review. If no meeting of the RPAC is scheduled within forty-five (45) days of receipt of the written request for review, then the RPAC will hold a special meeting to review such written request for review within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be rendered within ninety (90) days of receipt of the request for review. In any event, if a claim is not determined by the RPAC within ninety (90) days of receipt of written submission for review, it will be deemed to be denied.

The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the benefit determination is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant ESP provisions on which the decision was based. Such decision will also advise the claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the RPAC will be final and conclusive.

4.7 Arbitration. In the event the claims review procedure described in Section 4.6 of the ESP does not result in an outcome thought by the claimant to be in accordance with the ESP document, he may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within sixty (60) days after receiving the RPAC's denial or deemed denial of his request for review and before bringing suit in court. The arbitration will be conducted pursuant to the American Arbitration Association (" **AAA** ") Rules on Employee Benefit Claims.

The arbitrator will be mutually selected by the claimant and the RPAC from a list of arbitrators who are experienced in nonqualified deferred compensation plan benefit matters that is provided by the AAA. If the parties are unable to agree on the selection of an arbitrator within ten (10) days of receiving the list from the AAA, the AAA will appoint an arbitrator. The arbitrator's review will be limited to interpretation of the ESP document in the context of the particular facts involved. The claimant, the RPAC and the Employer agree to accept the award of the arbitrator as binding, and all exercises of power by the arbitrator hereunder will be final, conclusive and binding on all interested parties, unless found by a court of competent jurisdiction, in a final judgment that is no longer subject to review or appeal, to be arbitrary and capricious. The claimant, RPAC and the Employer agree that the venue for the arbitration will be in Dallas, Texas. The costs of arbitration will be paid by the Employer; the costs of legal representation for the claimant or witness costs for the claimant will be borne by the claimant; provided, that, as part of his award, the arbitrator may require the Employer to reimburse the claimant for all or a portion of such amounts.

The following discovery may be conducted by the parties: interrogatories, demands to produce documents, requests for admissions and oral depositions. The arbitrator will resolve any discovery disputes by such pre hearing conferences as may be needed. The Employer, RPAC and claimant agree that the arbitrator will have the power of subpoena process as provided by law. Disagreements concerning the scope of depositions or document production, its reasonableness and enforcement of discovery requests will be subject to agreement by the Employer and the claimant or will be resolved by the arbitrator. All discovery requests will be subject to the proprietary rights and rights of privilege and other protections granted by applicable law to the Employer and the claimant and the arbitrator will adopt procedures to protect such rights. With respect to any dispute, the Employer, RPAC and the claimant agree that all discovery activities will be expressly limited to matters directly relevant to the dispute and the arbitrator will be required to fully enforce this requirement.

The arbitrator will have no power to add to, subtract from, or modify any of the terms of the ESP, or to change or add to any benefits provided by the ESP, or to waive or fail to apply any requirements of eligibility for a benefit under the ESP. Nonetheless, the arbitrator will have absolute discretion in the exercise of its powers in the ESP. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the ESP.

4.8 Receipt and Release of Necessary Information. In implementing the terms of the ESP, the RPAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the RPAC or Plan Administrator deems to be necessary for such purposes. Any Covered Executive or estate claiming benefits under the ESP will furnish to the RPAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

4.9 Overpayment and Underpayment of Benefits. The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Covered Executive or his estate receives an underpayment of benefits, the Plan Administrator will direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Covered Executive or his estate, for whatever reason, the Plan Administrator may, in its sole and absolute discretion, withhold payment of any further benefits under the ESP until the overpayment has been collected or may require repayment of benefits paid under the ESP without regard to further benefits to which the Covered Executive or his estate may be entitled.

End of Article IV

ARTICLE V
OTHER BENEFIT PLANS OF THE COMPANY

5.1 Other Plans. Nothing contained in the ESP will prevent a Covered Executive before his death, or a Covered Executive's spouse or other beneficiary after such Covered Executive's death, from receiving, in addition to any payments provided for under the ESP, any payments provided for under any other plan or benefit program of the Employer, or which would otherwise be payable or distributable to him, his surviving spouse or beneficiary under any plan or policy of the Employer or otherwise. Nothing in the ESP will be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees and/or members of the Board.

5.2 Controlling Document. In the event that the provisions of any other plan or benefit program of the Employer conflict with any of the provisions contained in the ESP, the provisions of the ESP will control; provided, however, that in the event that a Covered Executive enters into a non-compete agreement as described in Section 3.2(e) and any provisions therein conflict with any of the provisions as set forth in this ESP, the provisions of the non-compete agreement will control.

End of Article V

ARTICLE VI
AMENDMENT AND TERMINATION OF THE ESP

6.1 Continuation. The Company intends to continue the ESP indefinitely, but nevertheless assumes no contractual obligation beyond the promise to pay the benefits described in the ESP.

6.2 Amendment of ESP. The Company, through an action of the Human Resources Committee may amend the ESP in its sole and absolute discretion, in any respect and at any time; provided, that no amendment may be made that reduces or diminishes the rights of any Covered Executive to the benefits described herein unless the affected Covered Executive receives at least one (1) year's advance notice of such amendment. Further, such advance notice to the Covered Executive will not be effective to enable the amendment of the ESP in either of the following two scenarios (a) if a Potential Change of Control occurs during the one (1) year notice period, or (b) within twenty four (24) months following a Change of Control.

6.3 Termination of ESP. The Company, through an action of the Human Resources Committee, may terminate or suspend the ESP in whole or in part at any time subject to the rules regarding the amendment of the ESP in Section 6.2 (*i.e.* , that one (1) year's advance notice is required and no such notice will be effective to enable the termination of the ESP if a Potential Change of Control occurs during the one (1) year notice period or within twenty four (24) months following a Change of Control). Notwithstanding any provision of the ESP to the contrary, upon the complete termination of the ESP pursuant to the provisions of this Section 6.3, the Human Resources Committee, in its sole and absolute discretion, may direct that the Plan Administrator treat each Eligible Executive as having incurred a Qualifying Termination and to commence the distribution of the benefits described in Article III to each such Eligible Executive or his estate, as applicable, to the extent that the commencement of such distribution comports with the requirements of section 409A of the Code.

6.4 Termination of Affiliate's Participation. Subject to the period relating to a Change of Control or Potential Change of Control described in Section 6.2, the Company may terminate an Affiliate's participation in the ESP at any time by an action of the Human Resources Committee and providing written notice to the Affiliate. The effective date of any such termination will be the later of the date specified in the notice of the termination of participation or the date on which the Plan Administrator can administratively implement such termination. If an Affiliate is disposed of by the Company pursuant to a stock or asset sale and a Covered Executive employed by such Affiliate is offered a comparable position with the purchaser of such stock or assets and refuses such position, the Covered Executive will not have incurred a Qualifying Termination for purposes of the ESP. Similarly, if an Affiliate is disposed of by the Company pursuant to a stock or asset sale and a Covered Executive employed by such Affiliate is offered a comparable position with the purchaser of such stock or assets and accepts such position, the Covered Executive will not have incurred a Qualifying Termination for purposes of the ESP.

End of Article VI

ARTICLE VII
MISCELLANEOUS

7.1 No Reduction of Employer Rights. Nothing contained in the ESP will be construed as a contract of employment between the Employer and a Covered Executive, or as a right of any Covered Executive to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Covered Executives, with or without cause.

7.2 Successor to the Company. The Company will require any successor or assign (whether direct or indirect, by purchase, exchange, lease, merger, consolidation, or otherwise) to all or substantially all of the property and assets of the Company and its Affiliates taken as a whole, to expressly assume the ESP and to agree to perform under this ESP in the same manner and to the same extent that the Company and its Affiliates would be required to perform it if no such succession had taken place. This Section 7.2 will not require any successor or assign of an Affiliate (whether direct or indirect, by purchase, exchange, lease, merger, consolidation or otherwise) to all or substantially all of the property and assets of such Affiliate to continue the ESP.

7.3 Provisions Binding. All of the provisions of the ESP will be binding upon the Company and its Affiliates and any successor to the Company or any such Affiliate. Likewise, the provisions of the ESP will be binding upon all persons who will be entitled to any benefit hereunder, their heirs and personal representatives.

End of Article VII

IN WITNESS WHEREOF , this Tenet Fourth Amended and Restated Executive Severance Plan has been executed this 9th day of August , 2018 effective as of August 8, 2018, except as specifically provided otherwise herein.

TENET HEALTHCARE CORPORATION

By: /s/ Paul Slavin

Paul Slavin, Vice President, Total Rewards and Workforce Analytics

APPENDIX A
ESP AGREEMENTS

Section 2.1(s) of the Tenet Executive Severance Plan (the " **ESP** ") provides that each Covered Executive will enter into an ESP Agreement which sets forth the terms and conditions of his benefits under the ESP and a form copy of such agreement will be attached to the ESP as Appendix A.

TENET EXECUTIVE SEVERANCE PLAN AGREEMENT*

THIS EXECUTIVE SEVERANCE PLAN AGREEMENT is made as of _____, 20__ by and between the Plan Administrator of the Tenet Executive Severance Plan (the " **ESP** ") on behalf of _____ (the " **Employer** "), and _____ (the " **Covered Executive** "). Capitalized terms used in this Agreement that are not defined herein will have the meaning set forth in the ESP.

1. Severance Pay with respect to the Covered Executive means _____. *[Note to Drafter: either state it means the same thing as in the ESP or spell out definition that will apply.]*

2. The Severance Period for the Covered Executive will be _____ with respect to a Qualifying Termination that occurs outside the Protection Period and _____ with respect to a Qualifying Termination that occurs during the Protection Period. *[Note to Drafter if periods selected vary from existing tables check to make sure new periods comply with section 409A.]*

3. As a condition of obtaining benefits under the ESP the Covered Executive agrees to comply with the restrictive covenants set forth in Section 3.7 of the ESP.

4. Any dispute or claim for benefits under the ESP must be resolved through the claims procedure set forth in Article IV of the ESP which procedure culminates in binding arbitration. By accepting the benefits provided under the ESP, the Covered Executive hereby agrees to binding arbitration as the final means of dispute resolution with respect to the ESP.

5. The ESP is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties will be bound by and have the benefit of each and every provision of the ESP, as amended from time to time.

IN WITNESS WHEREOF , the parties hereto have entered into this Agreement on _____, 20___.

COVERED EXECUTIVE

Title: _____

EMPLOYER

By: _____

Paul Slavin, Plan Administrator

*Used for Participants who entered the ESP before the execution date of the Tenet Fourth Amended and Restated Executive Severance Plan and whose participation has continued uninterrupted (i.e., are grandfathered)

TENET EXECUTIVE SEVERANCE PLAN AGREEMENT*

THIS EXECUTIVE SEVERANCE PLAN AGREEMENT is made as of **DATE** by and between the Plan Administrator of the Tenet Executive Severance Plan (the " **ESP** ") on behalf of **Tenet Business Services Corporation/Tenet Employment, Inc.** (the " **Employer** "), and **NAME** (the " **Covered Executive** "). Capitalized terms used in this Agreement that are not defined herein will have the meaning set forth in the ESP.

1. Severance Pay with respect to the Covered Executive base salary and average bonus as defined in Section 2.1(kk)(ii) of the ESP.

2. The Severance Period for the Covered Executive will be one (1) year with respect to a Qualifying Termination that occurs outside the Protection Period and one and one-half (1.5) years with respect to a Qualifying Termination that occurs during the Protection Period. [*Note to Drafter: alternatively may insert periods in Section 2.1(ll)(i)(A) and Section 2.1(ll)(B) of the ESP based on the position of the Covered Executive as determined by the Plan Administrator or Senior Vice President, Human Resources* .]

3. As a condition of obtaining benefits under the ESP the Covered Executive agrees to comply with the restrictive covenants set forth in Section 3.7 of the ESP.

4. Any dispute or claim for benefits under the ESP must be resolved through the claims procedure set forth in Article IV of the ESP which procedure culminates in binding arbitration. By accepting the benefits provided under the ESP, the Covered Executive hereby agrees to binding arbitration as the final means of dispute resolution with respect to the ESP.

5. The ESP is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties will be bound by and have the benefit of each and every provision of the ESP, as amended from time to time.

IN WITNESS WHEREOF , the parties hereto have entered into this Agreement on _____, 2018.

COVERED EXECUTIVE	**EMPLOYER**
	By:
_____	_____
COVERED EMPLOYEE NAME	Paul Slavin, Plan Administrator

*Used for Participants who enter ESP on and after the execution date of the Tenet Fourth Amended and Restated Executive Severance Plan

TENET HEALTHCARE CORPORATION

TENTH AMENDED AND RESTATED

SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

As Amended and Restated Effective as of April 1, 2018

TENET HEALTHCARE CORPORATION
TENTH AMENDED AND RESTATED
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN
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TENET HEALTHCARE CORPORATION
TENTH AMENDED AND RESTATED
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

ARTICLE I
PREAMBLE AND PURPOSE

1.1 Preamble. Tenet Healthcare Corporation (the " **Company** ") adopted the Supplemental Executive Retirement Plan (the " **SERP** ") effective November 1, 1984 to attract, retain, motivate and provide financial security to highly compensated or management employees (the " **Participants** ") who render valuable services to the Company and its " **Subsidiaries** ," as defined in Article II. The SERP was amended on various occasions and most recently amended and restated effective as of May 9, 2012, to make certain changes relating to a Change of Control and other termination event provisions

Effective November 6, 2013 the SERP was amended and restated to delegate authority to determine the employees eligible to participate in the SERP and clarify that the modifications made to the Retirement Benefit Plans Adjustment Factor apply in calculating a Participant's benefit irrespective of a Change of Control.

Effective May 7, 2014, the Compensation Committee froze participation in the SERP, meaning no new employees may become participants in the SERP on and after such date.

Effective August 28, 2014 the Retirement Plans Administrative Committee (" **RPAC** ") issued an administrative clarification regarding the determination of Final Average Earnings under the SERP when a participant continues employment past age sixty-five (65).

Effective March 2, 2015 the RPAC amended the SERP to delegate to the Senior Vice President, Human Resources and the Plan Administrator the authority to determine if and when earnings paid by an Affiliate who has not adopted the SERP as an Employer will be treated as Earnings for purposes of calculating Final Average Earnings under the SERP;

The RPAC amended and restated the SERP generally effective November 30, 2015, to (i) reflect that the SERP is closed to new Participants effective May 7, 2014, (ii) document the RPAC's prior administrative clarification that Final Average Earnings continue to accrue in accordance with the terms of the SERP in the event a participant continues working past age sixty-five (65), (iii) incorporate the March 2, 2015 amendment providing that the Senior Vice President, Human Resources and Plan Administrator have the authority to determine if and when earnings paid by an Affiliate who has not adopted the SERP as an Employer will be treated as Earnings for purposes of calculating Final Average Earnings under the SERP, (iv) delegate to the Senior Vice President, Human Resources and the Plan Administrator the authority to provide continued age and service credit for any Participant who transfers to an Affiliate who has not adopted the SERP as an Employer without the need for adoption of the SERP by such Affiliate, and (v) reflect that the name of the Compensation Committee has changed to the " **Human Resources Committee.** " This amended and restated SERP was known as the Tenet Healthcare Corporation Ninth Amended and Restated Supplemental Executive Retirement Plan.

By this instrument the RPAC desires to amend and restate the SERP effective April 1, 2018 to comply with the new ERISA regulations regarding Disability claims and make certain other administrative clarifications. This amended and restated SERP will be known as the Tenet Healthcare Corporation Tenth Amended and Restated Supplemental Executive Retirement Plan.

The Company or its Subsidiaries may adopt one or more domestic trusts to serve as a possible source of funds for the payment of benefit under this SERP.

1.2 Purpose. It is intended that this SERP will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Code, nor will it constitute a "funded plan," for purposes of such requirements. It also is intended that this SERP will be exempt from the participation and vesting requirements of Part 2 of Title I of the Employee Retirement Income Security Act of 1974, as amended (" **ERISA** "), the funding requirements of Part 3 of Title I of ERISA, and the fiduciary requirements of Part 4 of Title I of ERISA by reason of the exclusions afforded plans that are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS

When a word or phrase appears in this SERP with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Article II. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Article II, unless a different meaning is required by the context in which the word or phrase is used.

2.1 Actuarial Equivalent or Actuarial Equivalence means an amount equal in value to the aggregate amounts to be received under different forms of and/or times of payment, as determined by the SERP actuary, calculated using factors based on six percent (6%) interest and a fifty/fifty (50/50) blend of the RP-2000 sex distinct mortality tables. Actuarial Equivalent factors will be used for calculating Retirement Benefit amounts to be received under different times and/or forms of payment, for converting different forms and times of payment of Retirement Benefits and for determining the present value of Retirement Benefits.

2.2 Acquisition refers to a company of which substantially all of its assets or a majority of its capital stock are acquired by, or which is merged with or into, the Company or an Affiliate.

2.3 Affiliate means a corporation that is a member of a controlled group of corporations (as defined in section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is in common control (as defined in section 414(c) of the Code) with the Company, or any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company; provided, however, that for purposes of determining if an entity is an Affiliate under sections 414(b) or (c) of the Code ownership will be determined based on an ownership percentage of greater than fifty percent (50%):

2.4 Agreement means a written agreement substantially in the form of Exhibit A between the Company and a Participant. Each Agreement will form a part of the SERP with respect to the affected Participant. Once a Participant enters into an Agreement, such Agreement may be updated by the Company to reflect changes in the SERP made by the Company. Any such update will be attached to and form a part of the Participant's Agreement. In addition, any section references in such Agreement that change due to future amendments of the SERP will be deemed to be updated to reflect the revised Section number.

2.5 Alternate Payee means any spouse, former spouse, child, or other dependent of a Participant who is recognized by a DRO as having a right to receive all, or a portion of, the benefits payable under the SERP with respect to such Participant.

2.6 AMI SERP means the American Medical International Inc. Supplemental Executive Retirement Plan or any successor or substitute for such plan.

2.7 Board means the Board of Directors of the Company.

2.8 Bonus means any annual cash award paid under the Company's annual incentive plan.

2.9 Cause has the meaning set forth in the Executive Severance Plan.

2.10 Change of Control has the meaning set forth in the Executive Severance Plan.

2.11 **Code** means the Internal Revenue Code of 1986, as amended, and the regulations and rulings issued thereunder.

2.12 **Company** means Tenet Healthcare Corporation.

2.13 **Date of Employment** means the date on which a person began to perform services directly for the Employer as a result of an Acquisition or becoming an employee. In the event of an Acquisition, the Date of Employment may mean the date on which a person began to perform services directly for the acquired entity as provided in the Participant's offer letter or other communication.

2.14 **Date of Enrollment** means the date on or after June 1, 1984 on which an Eligible Employee first became a Participant in the SERP, provided that any Eligible Employee who becomes a Participant before June 1, 1984 will be deemed to have a Date of Enrollment of the later of the Participant's Date of Employment or June 1, 1984.

2.15 **Deferred Vested Retirement Benefit** means the benefit payable pursuant to Section 4.4.

2.16 **Disability** means the inability of a Participant to engage in any substantial gainful activity by reason of a mental or physical impairment expected to result in death or last for at least twelve (12) months, or the Participant, because of such a condition, is receiving income replacement benefits for at least three (3) months under an accident or health plan covering the Employer's employees.

2.17 **Disability Retirement Benefit** means the benefit payable pursuant to Section 4.8.

2.18 **DRO** means a domestic relations order that is a judgment, decree, or order (including one that approves a property settlement agreement) that relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of a Participant and is rendered under a state (within the meaning of section 7701(a)(10) of the Code) domestic relations law (including a community property law) and that:

(a) Creates or recognizes the existence of an Alternate Payee's right to, or assigns to an Alternate Payee the right to receive all or a portion of the benefits payable with respect to a Participant under the SERP;

(b) Does not require the SERP to provide any type or form of benefit, or any option, not otherwise provided under the SERP;

(c) Does not require the SERP to provide increased benefits (determined on the basis of actuarial value);

(d) Does not require the payment of benefits to an Alternate Payee that are required to be paid to another Alternate Payee under another order previously determined to be a DRO; and

(e) Clearly specifies: (i) the name and last known mailing address of the Participant and of each Alternate Payee covered by the DRO; (ii) the amount or percentage of the Participant's benefits to be paid by the SERP to each such Alternate Payee, or the manner in which such amount or percentage is to be determined; (iii) the number

of payments or payment periods to which such order applies; and (iv) that it is applicable with respect to this SERP.

2.19 Early Retirement means any Termination of Employment during the life of a Participant before the attainment of Normal Retirement Age and after attaining Early Retirement Age.

2.20 Early Retirement Age means the date the Participant attains age fifty-five (55) and has completed ten (10) Years of Service or attains age sixty-two (62) with no minimum Years of Service. To the extent provided by the Senior Vice President, Human Resources or Plan Administrator, a Participant will continue to be credited with age and Years of Service for employment with an Affiliate who has not adopted the SERP as an Employer.

For Eligible Employees who become Participants before August 3, 2011, a Participant will be credited with age and Years of Service during his severance period under the Severance Plan in effect as of the date in which the Participant commences participation in this SERP for purposes of determining if he satisfies the age and service conditions for Early Retirement Age as of the date of his Termination of Employment; provided, however, that, except as provided in Section 4.9(b), payment of Early Retirement Benefits under this SERP will not commence until the Participant has actually attained the requisite age and service conditions (*e.g.* , if the Participant who timely elected an Early Retirement Age of age fifty-five (55) and ten (10) Years of Service will satisfy such conditions during the Severance Period, he will be deemed to have satisfied such conditions as of his Termination of Employment but his Early Retirement Benefits will not commence until he actually attains age fifty-five (55) and completed ten (10) Years of Service). Furthermore, if after the date the Participant commences participation in this SERP, the applicable Severance Plan is amended to modify the severance period, such modification will not apply to the Participant for purposes of determining his Early Retirement Age under this SERP. As provided in Sections 3.2 and 4.2(b), a Participant will elect during the Initial Election Period which definition of Early Retirement Age will apply to him under the SERP. If the Participant fails to make such election, the Participant will be deemed to have elected age sixty-two (62) as his Early Retirement Age under the SERP. The additional age and service crediting for this severance period under the Severance Plan will not apply to any Eligible Employee who becomes a Participant on or after August 3, 2011.

2.21 Early Retirement Benefit means the benefit payable pursuant to Section 4.2.

2.22 Earnings means the base salary and any Bonus paid by the Employer or, to the extent determined by the Senior Vice President, Human Resources or the Plan Administrator, an Affiliate, to such Participant, but will exclude car and other allowances and other cash and non-cash compensation. The determination of Earnings will continue past Normal Retirement Age for a Participant who works beyond such date until the Participant's Termination of Employment as provided in the definition of Final Average Earnings.

2.23 Effective Date means April 1, 2018, except as specifically provided otherwise herein.

2.24 Eligible Children means all natural or adopted children of a Participant under the age of twenty-one (21), including any child conceived before the death of a Participant.

2.25 Eligible Employee means an Employee who is employed in a position designated as eligible to participate in this SERP by the Senior Vice President, Human Resources or the Plan

Administrator and approved by the Board or who satisfied the definition of Eligible Employee under the terms of a prior SERP document and who is not a Participant in the ERA. Effective on and after May 7, 2014 no additional Eligible Employees may become Participants in the SERP.

2.26 Employee means each select member of management or highly compensated employee receiving remuneration, or who is entitled to remuneration, for services rendered to the Employer, in the legal relationship of employer and employee. The term "Employee" will not include any person who is employed by the Employer in the capacity of an independent contractor, an agent or a leased employee even if such person is determined by the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a common law employee of the Employer.

2.27 Employer means the Company and each Affiliate who with the consent of the Senior Vice President, Human Resources or Plan Administrator has adopted the SERP as a participating employer. An Affiliate may evidence its adoption of the SERP either by a formal action of its governing body or by taking other administrative actions with respect to this SERP on behalf of its Eligible Employees. An entity will cease to be an Employer as of the date such entity ceases to be an Affiliate or the date specified by the Company.

2.28 Employment means any continuous period during which an Eligible Employee is actively engaged in performing services for the Employer or, to the extent determined by the Senior Vice President, Human Resources or the Plan Administrator, an Affiliate, plus the term of any leave of absence approved by the Employer or such Affiliate.

2.29 ERA means the Tenet Executive Retirement Account as amended from time to time.

2.30 ERISA means the Employee Retirement Income Security Act of 1974, as amended, and the regulations and rulings thereunder.

2.31 Executive Severance Plan or ESP means the Tenet Executive Severance Plan, as amended from time to time.

2.32 Final Average Earnings means the Participant's highest average monthly Earnings for any sixty (60) consecutive months during the ten (10) years, or actual Employment period if less, preceding Termination of Employment. The determination of Final Average Earnings will continue past Normal Retirement Age for a Participant who works beyond such date until the Participant's Termination of Employment; provided, however, that with respect to those Participants who joined the Tenet SERP before August 3, 2011, the determination of Final Average Earnings will continue after their Termination of Employment and during their severance period, if any, under the Executive Severance Plan. Effective on and after March 2, 2015, the Senior Vice President, Human Resources and the Plan Administrator have the authority to determine if and when earnings paid by an Affiliate who has not adopted the SERP will be treated as Earnings for purposes of calculating Final Average Earnings under the SERP.

2.33 Five Percent Owner means any person who own (or is considered as owning within the meaning of section 318 of the Code (as modified by section 416(i)(1)(B)(iii) of the Code)) more than five percent (5%) of the outstanding stock of the Company, or an Affiliate or stock possessing more than five percent (5%) of the total combined voting power of all stock of the Company or an Affiliate. The rules of sections 414(b), (c) and (m) of the Code will not apply for purposes of applying

these ownership rules. Thus, this ownership test will be applied separately with respect to the Company and each Affiliate.

2.34 Good Reason has the meaning set forth in the Executive Severance Plan.

2.35 Human Resources Committee means the Human Resources Committee of the Board (including any predecessor or successor to such committee in name or form) which has the authority to amend and terminate the SERP as provided in Article VIII.

2.36 Initial Election Period the thirty (30) day period immediately following the Participant's Date of Enrollment during which a Participant may elect the time at which to receive a distribution of Early Retirement Benefits pursuant to Section 4.2(b).

2.37 Key Employee means any employee or former employee including any deceased employee who at any time during the Plan Year was:

(a) an officer of the Company or an Affiliate having compensation of greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code for Plan Years beginning after December 31, 2002) (such limit is one hundred seventy thousand dollars ($170,000) for 2015);

(b) a Five Percent Owner; or

(c) One Percent Owner having compensation of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or One Percent Owner in accordance with section 1.415(c)-. 2(d)(4) of the Treasury Regulations (*i.e.* , W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections) under section 132(f) of the Code (regarding qualified transportation fringe benefits) or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special timing rules and special rules set forth, respectively, in sections 1.415(c)-2(e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (*i.e.* , the identification date). Employees that are Key Employees during such twelve (12) month period will be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (*i.e.* , since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder. For purposes of determining whether an employee or former employee is an officer, a Five Percent Owner or a One Percent Owner, the Company and each Affiliate will be treated as a separate employer (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.37(a), compensation from the Company and all Affiliates will be

taken into account (i.e., the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.37(a), no more than fifty (50) employees of the Company or its Affiliates (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50), the determination of which employees or former employees are officers will be determined based on who had the largest annual compensation from the Company and its Affiliates for the Plan Year. For the avoidance of doubt, for purposes of this Section 2.37 the controlled group rules under sections 414(b) and (c) of the Code will be applied based on the normal ownership percentage of greater than eighty percent (80%) rather than the fifty percent (50%) standard used in the definition of Affiliate.

2.38 Normal Retirement means any Termination of Employment during the life of a Participant on or after attaining Normal Retirement Age. To the extent a Participant continues Employment beyond Normal Retirement Age, he will continue to be credited with Earnings pursuant to the terms of the SERP.

2.39 Normal Retirement Age means the date on which the Participant attains age sixty-five (65) while employed by the Employer, or to the extent provided by the Senior Vice President, Human Resources or Plan Administrator, an Affiliate who has not adopted the SERP as an Employer.

2.40 Normal Retirement Benefit means the benefit payable pursuant to Section 4.1.

2.41 Normal Retirement Date means the first day of the calendar month following the Participant's attainment of Normal Retirement Age.

2.42 One Percent Owner means any person who would be described in Section 2.37 if "one percent (1%)" were substituted for "five percent (5%)" each place where it appears therein.

2.43 Participant means any Eligible Employee selected to participate in this SERP by the Senior Vice President, Human Resources or the Plan Administrator, each in its sole and absolute discretion, or an Eligible Employee who satisfied the definition of Participant under the terms of a prior SERP document and who, in each case, has entered into an Agreement and whose participation has not terminated.

2.44 Plan Administrator means the individual or entity appointed by the RPAC to handle the day-to-day administration of the SERP, including but not limited to, determining the eligibility of an Eligible Employee to be a Participant, the amount of a Participant's benefits and complying with all applicable reporting and disclosure obligations imposed on the SERP. If the RPAC does not appoint an individual or entity as Plan Administrator, the RPAC will serve as the Plan Administrator.

2.45 Plan Year means the fiscal year of this SERP, which will begin on January 1 each year and end on December 31 of such year.

2.46 Prior Service Credit Percentage means the percentage to be applied to a Participant's Years of Service with the Employer before his Date of Enrollment in the SERP, in accordance with the following formula:

Years of Service After Date of Enrollment	Prior Service Credit Percentage
During 1st year	25
During 2nd year	35
During 3rd year	45
During 4th year	55
During 5th year	75
After 5th year	100

In the event of the death or Disability of a Participant while an employee at any age or the Normal Retirement or Early Retirement of a Participant after age sixty (60), the Participant's Prior Service Credit Percentage will be one hundred (100).

2.47 Retirement Benefit means an Early Retirement Benefit, Normal Retirement Benefit, Disability Retirement Benefit, or Deferred Vested Retirement Benefit payable pursuant to Article IV.

2.48 Retirement Plans means a qualified or nonqualified defined contribution plan, other than the ERA which is addressed in Article III, maintained by the Employer, including, if applicable, any such plan maintained by an Employer before an Acquisition. In the event a Participant has an accrued benefit under a qualified or nonqualified defined benefit plan, the treatment of that benefit will be set forth in his Agreement.

2.49 Retirement Benefit Plans Adjustment Factor means the percentage calculated each year pursuant to administrative procedures adopted with respect to the SERP that is derived from the assumed benefit the Participant would be eligible for under Social Security and the Employer contribution portion of all Retirement Plans measured from the Participant's date of hire until the Participant's projected retirement regardless of whether the Participant participates in such plans; provided, however, that the Retirement Benefit Plans Adjustment Factor for a Participant who was covered by the SERP immediately before the Effective Date, will not be greater than the factor calculated with respect to such Participant as of December 31, 2013. The Retirement Benefits Plan Adjustment Factor will be applied only to the base salary component of Final Average Earnings and is a projection of the benefits payable under the Social Security regulations and Retirement Plans in effect at the time the benefit calculation is performed.

For any Participant actively employed by the Employer upon a Change of Control who subsequently has a Termination of Employment, the Retirement Benefit Plans Adjustment Factor for each such Participant will be adjusted to reflect the impact of the occurrence of the Termination of Employment at an age earlier than assumed under the initial calculation of the assumed benefit described above and will (i) be eliminated if the Participant is younger than age forty-five (45) upon such Termination of Employment, and (ii) if the Participant is age forty-five (45) or above, will be reduced by multiplying it by the following fraction:

1- [(65- Participant's age at Termination of Employment) /20].

For purpose of determining a Participant's age for calculating the above adjustments to the Retirement Benefit Plans Adjustment Factor, such age will be expressed in whole months and a

Participant will receive credit for any fractional months rounded up to the next whole month. In addition, a Participant may be credited with age for periods of employment with an Affiliate who has not adopted the SERP as an Employer, to the extent provided by the Senior Vice President, Human Resources or Plan Administrator.

2.50 RPAC means the Retirement Plans Administration Committee of the Company established by the Human Resources Committee, and whose members have been appointed by the Human Resources Committee. The RPAC will have the responsibility to administer the SERP and make final determinations regarding claims for benefits, as described in Article VI. In addition, the RPAC has limited amendment authority over the SERP as provided in Section 8.2.

2.51 SERP means the Tenth Amended and Restated Tenet Supplemental Executive Retirement Plan as set forth herein and as the same may be amended from time to time.

2.52 Severance Plan means the Tenet Executive Severance Plan, the Tenet Executive Severance Protection Plan or any or any similar, successor or replacement plan to such plans.

2.53 Surviving Spouse means the person legally married to a Participant (including effective August 3, 2011 a Participant's Domestic Partner as defined under the Criteria for Domestic Partnership Status under the Tenet Employee Benefit Plan and September 16, 2013 a same sex spouse) for at least one (1) year prior to the earlier of the Participant's death or Termination of Employment. If the Participant is not married at the time he incurs a Termination of Employment and marries (or enters into a domestic partnership) after that date, such spouse or domestic partner will not qualify as a Surviving Spouse for purposes of the SERP. Likewise, if the Participant is married (or in domestic partnership) at the time he incurs a Termination of Employment, divorces (or terminates such domestic partnership) after that date and remarries, his subsequent spouse (or domestic partner) will not qualify as a Surviving Spouse for purposes of the SERP.

2.54 Termination of Employment means the ceasing of the Participant's Employment or reduction in employment or other provision of services for any reason whatsoever, whether voluntarily or involuntarily, including by reason of Normal Retirement or Early Retirement, that qualifies as a separation from service under section 409A of the Code. For this purpose a Participant who is on a leave of absence that exceeds six (6) months and who does not have statutory or contractual reemployment rights with respect to such leave, will be deemed to have incurred a Termination of Employment on the first day of the seventh (7th) month of such leave. A Participant who transfers employment from an Employer to an Affiliate, regardless of whether such Affiliate has adopted the SERP as an Employer, will not incur a Termination of Employment; however, the extent to which such Participant will continue to accrue age and/or service for employment with such non-participating Affiliate will be determined by the Senior Vice President, Human Resources or Plan Administrator. A Participant who experiences a Qualifying Termination under the Severance Plan will incur a Termination of Employment under the SERP, subject to the special provisions regarding Early Retirement Age under Section 2.20.

2.55 Termination Without Cause means, for purposes of Section 4.9, the termination of a Participant by the Employer or an Affiliate without Cause or a voluntary Termination of Employment by the Participant for Good Reason within two (2) years of a Change of Control.

2.56 Trust means the rabbi trust established with respect to the SERP the assets of which are to be used for the payment of Retirement Benefits under this SERP.

2.57 **Trustee** means the individual or entity appointed as trustee under the Trust. After the occurrence of a Change of Control, the Trustee must be independent of any successor to the Company or any affiliate of such successor.

2.58 **Year** means a period of twelve (12) consecutive calendar months.

2.59 **Year of Service** means each complete year (up to a maximum of twenty (20)) of continuous service (up to age sixty-five (65)) as an employee of the Employer beginning with the Date of Employment with the Employer. The Senior Vice President, Human Resources or the Plan Administrator may also credit a Participant who transfers to an Affiliate that is not an Employer with age and/or service for his period of employment with such entity without the need for such Affiliate to adopt the SERP as an Employer. Years of Service will be deemed to have begun as of the first day of the calendar month of Employment and to have ceased on the last day of the calendar month of Employment. In the event a Participant incurs a Termination of Employment and is reemployed by the Employer, Service completed before such reemployment will be treated as Years of Service under the SERP to the extent provided in the Company's Rehire and Reinstatement Policy or any successor thereto, the provisions of which are incorporated herein by this reference. Years of Service before an employee's Date of Enrollment in the SERP will be credited for benefit accrual purposes on a pro-rated basis pursuant to Section 2.46.

End of Article II

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 Determination of Eligibility. Effective May 7, 2014 no new Eligible Employees may become Participants in the SERP. Each Eligible Employee who became a Participant in the SERP before May 7, 2014 will continue to participate in the SERP pursuant to the terms of this document.

3.2 Early Retirement Election. Before May 7, 2014, each Eligible Employee was required to elect during the Initial Election Period to commence the distribution of his Retirement Benefits on the first day of the calendar month following his Early Retirement as provided pursuant to Section 4.2. In making this election the Participant was required to specify the Early Retirement Age that will apply to him under the SERP (*i.e.* , age fifty-five (55) and ten (10) Years of Service or age sixty-two (62)). If the Eligible Employee failed to make this election during the Initial Election Period, he will be deemed to have affirmatively elected to commence the distribution of his Retirement Benefits on the first day of the calendar month following the date of his Retirement on or after attaining age sixty-two (62). Once made (or deemed made), this election cannot be revoked; however, the Participant may elect to defer payment of his Retirement Benefits pursuant to Section 4.5. Payment of such Early Retirement Benefit will be subject to the six (6) month restriction applicable to Key Employees, described in Section 5.1 of this SERP.

3.3 Loss of Eligibility Status. A Participant under this SERP who incurs a Termination of Employment, who ceases to be an Eligible Employee, or whose participation is terminated by the Senior Vice President, Human Resources or the Plan Administrator will continue as an inactive Participant under this SERP until the Participant has received the complete payment of his Retirement Benefits under this SERP. The Senior Vice President, Human Resources and the Plan Administrator have the authority to determine if and when earnings paid by an Affiliate who has not adopted the SERP as an Employer will be treated as Earnings for purposes of calculating Final Average Earnings under the SERP. Likewise, the Senior Vice President, Human Resources and the Plan Administrator have the authority to determine if age and service earned while working for an Affiliate who has not adopted the SERP as an Employer will be counted under this SERP as provided in Section 2.54.

3.4 Initial ERA Participation. A Participant who participated in the ERA before becoming a Participant in the SERP will be given credit for his Years of Service while a participant in the ERA for purposes of determining the amount of his Retirement Benefit under this SERP, but such Retirement Benefit will be reduced on an Actuarial Basis by his benefit under the ERA. The Participant's benefit under the ERA will be paid pursuant to the terms of the ERA and his Retirement Benefit under this SERP, if any, will be paid pursuant to the terms hereof.

3.5 Subsequent ERA Participation. A Participant's participation in this SERP will be frozen upon being named to the ERA. The Participant's Retirement Benefit under the SERP accrued as of the date his participation was frozen will commence pursuant to the terms hereof. Distribution of the Participant's ERA benefit will be made pursuant to the terms of the ERA. In the event such Participant subsequently resumes participation in the SERP, subject to the provisions of Section 3.1, he will be given credit for his Years of Service while a participant in the ERA for purposes of determining the amount of his Retirement Benefit under this SERP, but such Retirement Benefit will be reduced on an Actuarial Equivalent basis by his benefit under the ERA.

3.6 Initial AMI SERP Participation. A Participant who participated in the AMI SERP before becoming a Participant in the SERP will be entitled to a benefit under this SERP, if any, equal to the amount of his accrued benefit (as determined using the Actuarial Equivalent factors set forth in Section 2.1 of this SERP) less his prior accrued benefit under the AMI SERP (as determined using the actuarial equivalent factors set forth in the AMI SERP). The Participant's accrued benefit under the AMI SERP will be paid pursuant to the terms of the AMI SERP and his benefit under this SERP, if any, will be paid pursuant to the terms hereof.

End of Article III

ARTICLE IV
RETIREMENT BENEFITS

4.1 Normal Retirement Benefit.

(a) **Calculation of Normal Retirement Benefit** . Upon a Participant's Normal Retirement, the Participant will be entitled to receive a monthly Normal Retirement Benefit for the Participant's lifetime which is determined in accordance with the benefit formula set forth below, adjusted by the vesting percentage in Section 4.3. Payment of such Normal Retirement Benefit will commence as of the Participant's Normal Retirement Date, subject to the six (6) month restriction applicable to Key Employees, described in Section 5.1 of the SERP. Except as provided below, the amount of such monthly Normal Retirement Benefit will be determined by using the following formula:

X = [Al x [B1 + [B2 x C]] x [2.7% - D] x E] + [A2 x [B1 +[B2 x C] x 2.7% x E]

X = Normal Retirement Benefit

Al = Final Average Earnings (From Base Salary)
A2 = Final Average Earnings (From Bonus)
B1 = Years of Service After Date of Enrollment
B2 = Years of Service Prior to Date of Enrollment
C = Prior Service Credit Percentage
D = Retirement Benefit Plans Adjustment Factor
E = Vesting Percentage

Note: B1 and B2 Years of Service combined cannot exceed twenty (20) years.

To the extent that a Participant incurred a Termination of Employment before the Effective Date, such Participant's Normal Retirement Benefit, Early Retirement Benefit, Disability Retirement Benefit or Deferred Vested Retirement Benefit, as applicable, will be determined under the benefit formula as in effect at the time the Participant's Termination of Employment. However, the remaining provisions of this SERP, including but not limited to, the distribution provisions of Article IV and the claims procedures set forth in Section 7.6, will apply to such Participant.

(b) **Death After Commencement of Normal Retirement Benefits** . If a Participant who is receiving a Normal Retirement Benefit dies, his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent (50%) of the Participant's Normal Retirement Benefit.

(c) **Death After Normal Retirement Age But Before Normal Retirement** . If a Participant who is eligible for Normal Retirement dies while an employee after attaining age sixty-five (65), his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) the installments of the Normal Retirement Benefit which would have been payable to the Surviving Spouse or Eligible Children in accordance with Section 4.1(b) as if the Participant had retired

from the Employer on the day before he died. Distribution of such benefits will not be subject to the six (6) month restriction applicable to Key Employees.

4.2 Early Retirement Benefit.

(a) **Calculation of Early Retirement Benefit** . Upon a Participant's Early Retirement, the Participant will be entitled to receive a monthly Early Retirement Benefit for the Participant's lifetime commencing on the Participant's Normal Retirement Date, calculated in accordance with Section 4.1 and Section 4.3 with the following adjustments:

(i) Only the Participant's actual Years of Service, adjusted appropriately for the Prior Service Credit Percentage, as of the date of Early Retirement will be used.

(ii) For purposes of determining Final Average Earnings, only the Participant's Earnings as of the date of Early Retirement will be used.

(iii) To arrive at the payments to commence at Normal Retirement, the amount calculated under Section 4.2(a)(i) and Section 4.2(a)(ii) will be reduced by 0.25% for each month Early Retirement occurs before age sixty-two (62).

(b) **Early Payment of Benefits** . A Participant may elect during the Initial Election Period to receive a distribution of his Early Retirement Benefit on the first day of the calendar month following the date of his Early Retirement rather than on his Normal Retirement Date as specified in Section 4.2(a). Payment of such Early Retirement Benefit will be subject to the six (6) month restriction applicable to Key Employees, described in Section 5.1 of the SERP. A Participant who makes this election, will have the amount calculated under Section 4.2(a) further reduced by 0.25% for each month that the date of commencement of payment precedes the date on which the Participant will attain age sixty-two (62).

(c) **Death After Early Retirement Benefits Commence** . If a Participant dies after commencement of the payment of his Early Retirement Benefit, his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent (50%) of the Participant's Early Retirement Benefit.

(d) **Death After Early Retirement But Before Benefit Commencement** . If a Participant dies after his Early Retirement but before benefits have commenced his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent (50%) of the benefit that would have been payable on the date of the Participant's death had he elected to have benefits commence on that date. Distribution of such benefits will not be subject to the six (6) month restriction applicable to Key Employees.

(e) **Death of Employee After Attainment of Early Retirement Age but Before Early Retirement** . If a Participant dies after attaining Early Retirement Age but before taking Early Retirement, his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent

(50%) of the Participant's Early Retirement Benefit determined as if the Participant had retired on the day before his death with payments commencing on the first of the month following the Participant's death. The benefits payable to a Surviving Spouse or Eligible Children under this Section 4.2(e) will be no less than the benefits payable to a Surviving Spouse or Eligible Children under Section 4.4 (regarding the Deferred Vested Retirement Benefit) as if the Participant had died immediately before age fifty-five (55).

4.3 Vesting of Retirement Benefit. A Participant's interest in his Retirement Benefit will, subject to Section 9.4 (regarding Conditions Precedent), vest in accordance with the following schedule:

Years of Service	Vesting Percentage
Less than 5	0
5 but less than 6	25
6 but less than 7	30
7 but less than 8	35
8 but less than 9	40
9 but less than 10	45
10 but less than 11	50
11 but less than 12	55
12 but less than 13	60
13 but less than 14	65
14 but less than 15	70
15 but less than 16	75
16 but less than 17	80
17 but less than 18	85
18 but less than 19	90
19 but less than 20	95
20 or more	100

Notwithstanding the foregoing, a Participant who is at least sixty (60)years old and who has completed at least five (5) Years of Service will be fully vested, subject to Section 9.4 (regarding Conditions Precedent), in his Retirement Benefit. Except as required otherwise by applicable law, no Years of Service will be credited for Service after age sixty-five (65) or for more than twenty (20) years.

4.4 Deferred Vested Retirement Benefit. Upon any Termination of Employment of the Participant before Normal Retirement or Early Retirement for reasons other than death or Disability, such Participant will be entitled to a Deferred Vested Retirement Benefit, commencing on the Participant's Normal Retirement Date, calculated under Section 4.1 and 4.3 but with the following adjustments:

(a) **Calculation of Years of Service** . Only the Participant's actual Years of Service, adjusted appropriately for the Prior Service Credit Percentage, as of the date of his Termination of Employment will be used.

(b) **Calculation of Earnings** . For purposes of determining Final Average Earnings, as used in Section 4.1, only the Participant's Earnings before the date of his Termination of Employment will be used.

(c) **Early Termination Reduction** . Subject to the maximum reduction under Section 4.4(g), to arrive at the payments to commence at the Participant's Normal Retirement Date, the amount calculated under Section 4.1(a) will be reduced by 0.25% for each month the Participant's Termination of Employment occurs before age sixty-two (62).

(d) **Death After Commencement of Payments** . If a Participant dies after commencement of the payment of his Deferred Vested Retirement Benefit under this Section 4.4, his Surviving Spouse or Eligible Children will be entitled at Participant's death to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent (50%) of the Participant's Deferred Vested Retirement Benefit.

(e) **Death after Termination of Employment** . If a Participant, who has a vested interest under Section 4.3, dies after Termination of Employment but at death is not receiving any Deferred Vested Retirement Benefits under this SERP and was not eligible for an Early Retirement Benefit pursuant to Section 4.2, his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) commencing on the date that would have been the Participant's Normal Retirement Date, a benefit equal to fifty percent (50%) of the Deferred Vested Retirement Benefit which would have been payable to the Participant at his Normal Retirement Date.

(f) **Death While an Employee** . If a Participant, who has a vested interest under Section 4.3, dies while still actively employed by the Employer or, to the extent provided by the Senior Vice President, Human Resources or Plan Administrator, an Affiliate, before he was eligible for Early Retirement, his Surviving Spouse or Eligible Children will be entitled at the Participant's death to receive a benefit equal to fifty percent (50%) of the Participant's Retirement Benefit (in accordance with Sections 4.6 and 4.7) calculated as if the Participant was age fifty-five (55) and eligible for Early Retirement on the day before the Participant's death; provided, however, that the combined reductions for Early Retirement and early payment will not exceed twenty-one percent (21%) of the amount calculated under Sections 4.2(a)(i) and (ii). Distribution of such benefits will not be subject to the six (6) month restriction applicable to Key Employees.

(g) **Early Termination Reduction Limit** . To arrive at the amount of the Deferred Vested Retirement Benefit payments to commence at the Participant's Normal Retirement Date, the Early Termination reduction calculated under Section 4.4(c) (and indirectly under Section 4.4(d), and Section 4.4(e)) will be limited to the maximum percentage reduction for Early Retirement at age fifty-five (55) (*i.e.* , twenty-one percent (21%)).

4.5 Deferral of Distributions. A Participant may elect to defer payment of his Normal Retirement Benefit payable pursuant to Section 4.1, his Early Retirement Benefit payable pursuant to Section 4.2 or his Deferred Vested Retirement Benefit payable pursuant to Section 4.4 for a period of at least five (5) years by making an election to defer such distribution at least twelve (12) months before the date that the Normal Retirement Benefit, Early Retirement Benefit or Deferred

Vested Retirement Benefit would otherwise be paid (*i.e.* , at least twelve (12) months before a Termination of Employment). In the event that the Participant becomes entitled to a distribution pursuant to Section 4.1, Section 4.2 or Section 4.4 during this twelve (12) month period, the deferral election will be of no effect and payment of the Participant's benefits will commence at the time specified in Section 4.1, Section 4.2 or Section 4.4, as applicable. A Participant who becomes entitled to distribution of a Disability Retirement Benefit pursuant to Section 4.9 may not elect to defer payment of such distribution pursuant to this Section 4.5 and any deferral election made by such Participant will be null and of no effect.

4.6 Duration of Benefit Payment.

(a) **Participant Benefit Payments** . The Normal Retirement Benefit, Early Retirement Benefit, Disability Retirement Benefit or Deferred Vested Retirement Benefit under the SERP will be payable to the Participant in the form of a monthly benefit payable for life.

(b) **Surviving Spouse Benefit Payments** . The benefit payable to a Surviving Spouse under the SERP will be paid in the form of a monthly benefit payable for life; provided, that all benefits payable to the Surviving Spouse are subject to actuarial reduction based on the factors in Section 2.1 if the Surviving Spouse is more than three (3) years younger than the Participant.

(c) **Eligible Children Benefit Payments** . The benefit payable to a Participant's Eligible Children under the SERP will be paid in the form of a monthly benefit payable until each such child reaches age twenty-one (21).

4.7 Recipients of Benefit Payments.

(a) **Death without Surviving Spouse** . If a Participant dies without a Surviving Spouse but is survived by any Eligible Children, then the Participant's Retirement Benefit will be paid to his Eligible Children. The total monthly benefit payable will be equal to the monthly benefit that a Surviving Spouse would have received without actuarial reduction. This benefit will be paid in equal shares to all Eligible Children until the youngest of the Eligible Children attains age twenty-one (21). When any of the Eligible Children reaches twenty-one (21), his share of the total monthly benefit will be reallocated equally to the remaining Eligible Children.

(b) **Death of Surviving Spouse** . If the Surviving Spouse dies after the death of the Participant but is survived by Eligible Children then the total monthly benefit previously paid to the Surviving Spouse will be paid in equal shares to all Eligible Children until the youngest of the Eligible Children attains age twenty-one (21). When any of the Eligible Children reaches twenty-one (21), his share of the total monthly benefit will be reallocated equally to the remaining Eligible Children.

(c) **Death Without Surviving Spouse or Eligible Children** . If the Participant dies without a Surviving Spouse or Eligible Children, no additional benefits will be paid under this SERP with respect to that Participant.

4.8 Disability.

(a) **Disability Retirement Benefit** . Any Participant who incurs a Disability will upon reaching Normal Retirement Age be paid, as a Disability Retirement Benefit, the Normal Retirement Benefit in accordance with Section 4.1 based on his vested interest as determined under Section 4.3 and Section 4.8(b). Payment of the Disability Retirement Benefit will begin as of the Participant's Normal Retirement Date. A Participant who is entitled to a Disability Retirement Benefit may not elect to defer payment of such distribution pursuant to Section 4.5. Unless otherwise required under Code Section 409A, amounts payable pursuant to this Section 4.8(a) will not be subject to the six (6) month restriction applicable to Key Employees.

(b) **Continued Accrual of Vesting Service** . Upon a Participant's Disability while an employee of the Employer, or to the extent provided by the Senior Vice President, Human Resources or the Plan Administrator, an Affiliate, the Participant will continue to accrue Years of Service for purposes of vesting under Section 4.3 of this SERP during his Disability until the earliest of his:

(i) Recovery from Disability;

(ii) Attainment of Normal Retirement Age; or

(iii) Death.

(c) **Not Eligible for Early Retirement Benefit** . A Participant who is Disabled will not be entitled to receive an Early Retirement Benefit under this SERP.

(d) **Calculation of Earnings** . For purposes of calculating the amount of the Disability Retirement Benefit, the Participant's Final Average Earnings will be determined using his Earnings up to the date of Disability.

(e) **Death Before Attainment of Early Retirement Age** . If a Participant, who has a vested interest as determined under this Section 4.8 and Section 4.3, dies while on Disability before he attained Early Retirement Age, his Surviving Spouse or Eligible Children will be entitled at the Participant's death to receive a benefit equal to fifty percent (50%) of the Participant's Retirement Benefit (in accordance with Sections 4.6 and 4.7) calculated under Section 4.2 as if the Participant was age fifty-five (55) and eligible for Early Retirement on the day before the Participant's death; provided, however, that the combined reductions for Early Retirement and early payment will not exceed twenty-one percent (21%) of the amount calculated under Sections 4.2(a)(i) and (ii). Distribution of such benefits will not be subject to the six (6) month restriction applicable to Key Employees.

(f) **Death After Attainment of Early Retirement Age** . If a Participant dies after attaining Early Retirement Age while on Disability, his Surviving Spouse or Eligible Children will be entitled to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent (50%) of the Participant's Early Retirement Benefit determined as if the Participant had retired on the day before his death with payments commencing on the first of the month following the Participant's death. The benefits payable to a Surviving Spouse or Eligible Children under this Section 4.8(f) will be no less than the benefits payable to a Surviving Spouse or Eligible Children under Section 4.4 (regarding the Deferred Vested Retirement Benefit) as if the Participant

had died immediately prior to age fifty-five (55). Distribution of such benefits will not be subject to the six (6) month restriction applicable to Key Employees.

(g) **Death after Commencement of Payments** . If a Participant dies after his commencement of Disability Retirement Benefits under this Section 4.8, his Surviving Spouse or Eligible Children will be entitled at the Participant's death to receive (in accordance with Sections 4.6 and 4.7) a benefit equal to fifty percent (50%) of the Participant's Disability Retirement Benefit.

4.9 Change of Control.

(a) **Calculation of Benefits** .

(i) **Post-April 1994 Employees** . In the event of a Change of Control while this SERP remains in effect, each Participant will be fully vested in his Retirement Benefit, without regard to the Participant's Years of Service and the amount of such benefit will be calculated by granting the Participant Prior Service Credit under Sections 4.1, 4.2 and 4.4 for all Years of Service prior to his Date of Enrollment, plus, for Eligible Employees who become Participants before August 3, 2011, crediting of additional Years of Service at the end of the Severance Period and crediting of age during the Severance Period as determined under Section 3.1(h) of the ESP. Moreover, the Retirement Benefit Plans Adjustment Factor will be adjusted as set forth in Section 2.49. In addition, with respect to a Participant who (A) is an active employee, (B) has not yet begun to receive benefit payments under the SERP, and (C) incurs a Termination without Cause within two (2) years following a Change of Control, the provisions of Section 9.4(b) (Regarding Conditions Precedent) will not apply.

(ii) **Employees as of April 1, 1994** . With respect to a Participant who is an employee actively at work on April 1, 1994, with the corporate office or a division of the Employer which has not been declared to be a discontinued operation, who has not yet begun to receive benefit payments under the SERP and who incurs a Termination without Cause within two (2) years following a Change of Control, the provisions of Section 4.9(a)(i) above will not apply and instead a Participant's Retirement Benefit under this SERP will be determined by:

(A) granting the Participant full Prior Service Credit under Sections 4.1, 4.2 and 4.4 for all Years of Service prior to his Date of Enrollment; plus, for Eligible Employees who become Participants before August 3, 2011, crediting of additional Years of Service at the end of the Severance Period and crediting of age during the Severance Period as determined under Section 3.1(h) of the ESP.

(B) with respect to a covered Participant who incurs a Termination without Cause within two (2) years following a Change of Control, crediting the Participant with three (3) additional Years of Service (with total Years of Service not to exceed twenty (20) years), which

will be in lieu of any additional Years of Service and age provided under Section 3.1 of the ESP;

(C) The benefit formula in Section 4.1(a) will be applied by defining A1 as "the greater of current monthly Earnings (from Base Salary) or Final Average Earnings (from Base Salary)," and A2 as "the greater of current monthly Earnings (from Bonus) or Final Average Earnings (from Bonus)";

(D) The Retirement Benefits Plan Adjustment Factor will be adjusted as set forth in Section 2.49;

(E) The provisions of Section 9.4(b) (regarding Conditions Precedent) will not apply; and

(F) Further, the Participant will be fully vested in such Retirement Benefit without regard to his Years of Service.

(b) **Payment of Benefits** . Upon the Participant's Termination of Employment within two (2) years following the occurrence of a Change of Control (except on account of a liquidation or dissolution of the Company), the Participant will begin to receive such Retirement Benefit (notwithstanding the payout timing rules in Sections 2.21, 3.2, 4.2(a), 4.2(b), and 4.4) commencing on the first day of the calendar month following the date of such Termination of Employment without reduction by virtue of Sections 4.2(a), 4.2(b) or 4.4(c), taking into account the crediting of the additional severance period under ESP Section 3.1(h) and SERP Section 4.9(a). In the event that the Participant does not incur a Termination of Employment within such two (2) year period or in the event of a Change of Control on account of the liquidation or dissolution of the Company, the Participant will begin to receive the Retirement Benefit described in Section 4.9(a) as of his Normal Retirement Date or Early Retirement Date, as the case may be, with no reduction by virtue of Section 4.2(a), Section 4.2(b) or Section 4.4(c), subject to the six (6) month restriction applicable to Key Employees described in Section 5.1.

4.10 Golden Parachute Limitation. The calculation and administration of any liability that may arise out of the "golden parachute" provisions of sections 280G and 4999 of the Code will be addressed as set forth in the Executive Severance Plan.

4.11 Executive Severance Plan. A Participant who is entitled to receive benefits under this SERP following a Termination of Employment, will to the extent applicable have such benefits calculated under the provisions of this SERP and Section 3.1(h) of the ESP. In the event of any direct conflict between the terms of this SERP and the ESP with respect to the calculation of benefits, the ESP will control.

4.12 Impact of Reemployment on Benefits. If a Participant incurs a Termination of Employment and begins receiving Retirement Benefit payments from the SERP and such Participant is reemployed by the Employer or an Affiliate, then such Participant's Retirement Benefit payments will continue as scheduled during the period of his reemployment.

End of Article IV

ARTICLE V
PAYMENT

5.1 Commencement of Payments. Benefit payments under this SERP generally will begin on the Participant's Normal Retirement Date; provided, that in the case of a benefit payable on account of Early Retirement, a Termination of Employment within two (2) years following a Change of Control or death, benefit payments will begin not later than the first day of the calendar month following the occurrence of the event which entitles the Participant (or a Surviving Spouse or Eligible Children) to benefits under this SERP. Benefit payments under this SERP that are payable to a Key Employee on account of a Termination of Employment will be delayed for a period of six (6) months following such Participant's Termination of Employment. On the day following the expiration of such six (6) month period, the Participant will receive a catch-up payment equal to the amount of benefits that would have been paid during such six (6) month period but for the provisions of this Section 5.1 and the remainder of such payments will be paid according to the terms of the SERP.

5.2 Withholding; Unemployment Taxes. Any taxes required to be withheld from a Participant's benefit by the Federal or any state or local government will be withheld from payments under this SERP to the extent required by the law in effect at the time payments are made.

5.3 Recipients of Payments. All Retirement Benefit payments to be made by the Employer under the SERP will be made to the Participant during his lifetime. All subsequent payments under the SERP will be made by the SERP to the Participant's Surviving Spouse or Eligible Children.

5.4 No Other Benefits. No other benefits will be payable under this SERP to the Participant or his Surviving Spouse or Eligible Children by reason of the Participant's Termination of Employment or otherwise, except as specifically provided herein.

5.5 No Lump Sum Form of Payment. Except with respect to permitted SERP terminations under Section 8.3, no lump sum form of payment will be payable from the SERP with respect to any Participant regardless of when such Participant incurs a Termination of Employment.

End of Article V

ARTICLE VI
PAYMENT LIMITATIONS

6.1 Spousal Claims.

(a) An Alternate Payee may be awarded all or a portion of the Participant's Retirement Benefits pursuant to the terms of a DRO, in which case such benefits will be payable to the Alternate Payee at the same time and in the same form of payment as the Participant's.

(b) The Alternate Payee will be responsible for payment of any federal, state and local taxes.

(c) The Plan Administrator has sole and absolute discretion to determine whether a judgment, decree or order is a DRO, to determine whether a DRO will be accepted for purposes of this Section 6.1 and to make interpretations under this Section 6.1, including determining who is to receive benefits, all calculations of benefits and determinations of the form of such benefits, and the amount of taxes to be withheld. The decisions of the Plan Administrator will be binding on all parties with an interest.

(d) Any benefits payable to an Alternate Payee pursuant to the terms of a DRO will be subject to all provisions and restrictions of the SERP and any dispute regarding such benefits will be resolved pursuant to the SERP claims procedure in Article VII.

6.2 Legal Disability. If a person entitled to any payment under this SERP will, in the sole judgment of the Plan Administrator, be under a legal disability, or otherwise will be unable to apply such payment to his own interest and advantage, the Plan Administrator, in the exercise of its discretion, may direct the Company or payor of the benefit to make any such payment in any one or more of the following ways:

(a) Directly to such person;

(b) To his legal guardian or conservator; or

(c) To his spouse or to any person charged with the duty of his support, to be expended for his benefit and/or that of his dependents.

The decision of the Plan Administrator will in each case be final and binding upon all persons in interest, unless the Plan Administrator will reverse its decision due to changed circumstances.

6.3 Assignment. Except as provided in Section 6.1, no Participant, Surviving Spouse or Eligible Child will have any right to assign, pledge, transfer, convey, hypothecate, anticipate or in any way create a lien on any amounts payable hereunder. No amounts payable hereunder will be subject to assignment or transfer or otherwise be alienable, either by voluntary or involuntary act, or by operation of law, or subject to attachment, execution, garnishment, sequestration or other seizure under any legal, equitable or other process, or be liable in any way for the debts or defaults of Participants or their Surviving Spouses or Eligible Children. The Company may assign all or a portion of this SERP to any Affiliate which employs any Participant.

End of Article VI

ARTICLE VII
ADMINISTRATION OF THE PLAN

7.1 The RPAC. The overall administration of the SERP will be the responsibility of the RPAC.

7.2 Powers of the RPAC. The RPAC will have the sole and absolute discretion regarding the exercise of its powers and duties under this SERP. In order to effectuate the purposes of the SERP, the RPAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the SERP;

(c) To construe the SERP and to make equitable adjustments for any mistakes or errors made in the administration of the SERP;

(d) To carry out the duties expressly reserved to it under the SERP; and

(e) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the SERP and the Trust (i) when differences of opinion arise between the Company, an Affiliate, the Plan Administrator, the Trustee, a Participant, or any of them, and (ii) whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the SERP for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the RPAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the SERP.

7.3 Appointment of Plan Administrator. The RPAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the SERP on a daily basis. The RPAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the RPAC.

7.4 Duties of Plan Administrator. The Plan Administrator will have sole and absolute discretion regarding the exercise of its powers and duties under this SERP. The Plan Administrator will have the following powers and duties:

(a) To direct the administration of the SERP in accordance with the provisions herein set forth;

(b) To adopt rules of procedure and regulations necessary for the administration of the SERP, provided such rules are not inconsistent with the terms of the SERP;

(c) To determine all questions with regard to rights of Participants under the SERP including, but not limited to, questions involving who is an Eligible Employee and the amount of a Participant’s benefits;

(d) To enforce the terms of the SERP and any rules and regulations adopted by the RPAC;

(e) To review and render decisions respecting a claim for a benefit under the SERP;

(f) To furnish the Employer with information required for tax or other purposes;

(g) To engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) To prescribe procedures to be followed by distributees in obtaining benefits;

(i) To receive from the Employer and from Participants such information as is necessary for the proper administration of the SERP;

(j) To create and maintain such records and forms as are required for the efficient administration of the SERP;

(k) To make all determinations and computations concerning the benefits to which any Participant is entitled under the SERP;

(l) To give the Trustee specific directions in writing with respect to:

(i) the making of distribution payments, giving the names of the payees, the amounts to be paid and the time or times when payments will be made; and

(ii) the making of any other payments which the Trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator or the Company;

(m) To comply with all applicable lawful reporting and disclosure requirements of ERISA;

(n) To comply (or transfer responsibility for compliance to the Trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(o) To construe the SERP, in its sole and absolute discretion, and make equitable adjustments for any mistakes and errors made in the administration of the SERP.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the SERP.

7.5 Indemnification of the RPAC and Plan Administrator. To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations, the Company agrees to hold harmless and indemnify the RPAC and Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising

out of any act or omission relating to or in connection with the SERP other than losses resulting from the RPAC's, or any such person's fraud or willful misconduct.

7.6 Claims for Benefits.

(a) **Initial Claim** . In the event that an Employee, Eligible Employee, Participant, Surviving Spouse, or Eligible Child (a "claimant") claims to be eligible for benefits, or claims any rights under this SERP, such claimant must complete and submit such claim forms and supporting documentation as will be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any claimant who feels unfairly treated as a result of the administration of the SERP must file a written claim, setting forth the basis of the claim, with the Plan Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the claimant may use representation and may examine this SERP, and any other pertinent documents generally available to Participants that are specifically related to the claim and may appoint an authorized representative to pursue the claim on his behalf. References to the claimant include his authorized representative, when applicable.

Different claims procedures apply to claims for benefits on account of Disability, referred to as "Disability claims," and all other claims for benefits, referred to as "non-Disability claims."

(b) **Non-Disability Claims** .

(i) **Initial Decision** . If a claimant files a non-Disability claim, written notice of the disposition of such claim will be furnished to the claimant within ninety (90) days after the claim is filed with the Plan Administrator unless special circumstances require an extension of time for processing the claim. Such extension will not exceed ninety (90) days and no extension will be allowed unless, within the initial ninety (90)-day period, the claimant is sent an extension notice indicating the special circumstances requiring the extension and specifying a date by which the Plan Administrator expects to issue its final decision. If the claim is denied, the Plan Administrator's notice will set forth:

(A) The specific reason or reasons for the denial

(B) Specific references to pertinent SERP provisions on which the Plan Administrator based its denial;

(C) A description of any additional material and information needed for the claimant to perfect his claim and an explanation of why the material or information is needed;

(D) A statement that the claimant may:

(1) Appeal the claim in writing to the RPAC, including a description of such appeal procedures and the time limits applicable to such procedures;

(2) Review pertinent SERP documents;

(3) Submit issues and comments in writing; and

(4) Pursue arbitration following the denial of the claim on appeal;

(E) A statement that any appeal that the claimant wishes to make of the adverse determination must be made in writing to the RPAC within ninety (90) days after receipt of the Plan Administrator's notice of denial of benefits; and

(F) A statement that his failure to appeal the action to the RPAC in writing within the ninety (90)-day period will render the Plan Administrator's determination final, binding, and conclusive.

All benefits provided in this SERP as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(ii) **Appeal of Denied Non-Disability Claim** . Within ninety (90) days after receiving written notice of the Plan Administrator's denial of his initial non-Disability claim, the claimant may file with the RPAC a written appeal of his claim. If the claimant does not file an appeal within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant will be deemed to have accepted the Plan Administrator's written disposition, unless the claimant was physically or mentally incapacitated so as to be unable to file an appeal within the ninety (90) day period.

(iii) **Decision on Appeal of Non-Disability Claim** . After receipt by the RPAC of a written appeal of a non-Disability claim, the RPAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The RPAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on appeal of the claim will be made by the RPAC at its next meeting following receipt of the appeal. If no meeting of the RPAC is scheduled within forty-five (45) days of receipt of the appeal, then the RPAC will hold a special meeting to review such appeal within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be made within ninety (90) days of receipt of the appeal. In any event, if a claim is not determined by the RPAC within ninety (90) days of receipt of the appeal, it will be deemed to be denied.

The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the determination on appeal is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant SERP provisions on which the decision was based. Such decision will also advise the claimant that he may

receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the RPAC will be final and conclusive.

(c) **Disability Claims** . The SERP will ensure that all Disability claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision by ensuring that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, such as a medical or vocational expert, must not be based upon the likelihood that the individual will support the denial of benefit

(i) **Initial Decision on Disability Claim** . The Plan Administrator will notify the claimant the initial decision on a Disability claim no later than forty-five (45)-days after receipt of the claim by the SERP. This period may be extended by the Plan Administrator for up to thirty (30) days provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the SERP and the claimant is notified before the expiration of the initial forty-five (45)-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to make a decision. If, before the first thirty (30)-day extension period, the Plan Administrator determines that, due to matters beyond the control of the SERP, a decision can not be made within that extension period, the period for making the initial benefit determination may be extended for up to an additional thirty (30) days provided that the claimant is notified before the expiration of the first thirty (30)-day extension period of the circumstances requiring the extension and the date as of which the Plan Administrator expects to issue a decision. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a benefit by reason of Disability is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues and the claimant will be given at least forty-five (45) days within which to provide the specified information.

The claimant will be provided with written or electronic notification of any adverse benefit determination (i.e., denial) of a Disability claim, in a culturally and linguistically appropriate manner by providing oral language services (such as a telephone customer assistance hotline) that includes answering questions in any “applicable non-English language,” as defined below, and providing assistance with filing claims and appeals in any applicable non-English language, providing, upon request, a notice in any applicable non-English language and including in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the SERP. For this purpose a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county to which a notice is sent is literate only in the same non-English language, as determined in guidance issued by the Secretary of the Department of

Labor. The notification will set forth, in a manner calculated to be understood by the claimant:

(A) the specific reason or reasons for the denial;

(B) reference to the specific SERP provisions on which the denial is based;

(C) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(D) a description of the SERP's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502 of ERISA following the denial of an appeal;

(E) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the SERP of health care professionals treating the claimant and the vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the SERP in connection with the denial, without regard to whether the advice was relied on in making the benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the SERP made by the Social Security Administration;

(F) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the SERP to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(G) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the SERP relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

(H) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

(ii) **Appeal of Denial of Disability Claim**

(A) **Opportunity for Full and Fair Review** . A claimant will be provided a reasonable opportunity to appeal the denial of his Disability claim under which there will be a full and fair review of the claim and the denial. Accordingly:

(1) a claimant will be provided one hundred and eighty (180) days following receipt of notice of the denial of the Disability claim to appeal such determination;

(2) a claimant will be provided the opportunity to submit written comments, documents, records or other information relating to the Disability claim on appeal;

(3) a claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Disability claim;

(4) appellant review will take into account all comments, documents, records and other information submitted by the claimant relating to the Disability claim without regard to other such information once submitted or considered in the initial benefit determination;

(5) such appeal will not afford deference to the initial denial and will be conducted by the RPAC, which is an appropriate Named Fiduciary of the SERP and which will neither be the individual who denied the Disability claim that is subject to the appeal nor the subordinate of such individual;

(6) in the case of any appeal of a denied Disability claim that is based in whole or in part on a medical judgment, the claimant will be entitled to a review by the RPAC based on the RPAC's consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment whereby such professional is neither an individual who was consulted in connection with the denial that is the subject of the appeal nor the subordinate of any such individual;

(7) the claimant will be provided with the identity of the medical or vocational experts whose advice was obtained on behalf of the SERP in connection with the denial of the Disability claim, without regard to whether the advice was relied upon in making the benefit determination; and

(8) as soon as possible and sufficiently in advance of the date on which the notice on the appeal is required to be provided, the RPAC or its delegate will provide the claimant, free of charge, with any new or additional evidence and/or rationale considered, relied upon, or generated by the SERP in connection with the Disability claim.

(B) **Timing of Decision on Appeal of Disability Claim** . The decision on appeal of the claim will be made by the RPAC at its next meeting following receipt of the appeal. If no meeting of the RPAC is

scheduled within forty-five (45) days of receipt of the appeal, then the RPAC will hold a special meeting to review such appeal within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be made within ninety (90) days of receipt of the appeal. In any event, if the appeal is not determined by the RPAC within ninety (90) days after its receipt of the appeal, it will be deemed to be denied. .

(C) **Decision on Appeal of Disability Claim** . The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the determination on appeal is made. The claimant will be provided with written or electronic notification of the SERP's benefit determination on appeal in a culturally and linguistically appropriate manner by providing oral language services (such as a telephone customer assistance hotline) that includes answering questions in any "applicable non-English language," as defined below, and providing assistance with filing claims and appeals in any applicable non-English language, providing, upon request, a notice in any applicable non-English language and including in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the SERP. For this purpose a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county to which a notice is sent is literate only in the same non-English language, as determined in guidance issued by the Secretary of the Department of Labor. If the appeal is denied, the notification will set forth, in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the appeal decision;

(2) reference to the specific SERP provisions on which the appeal decision is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Disability claim for benefits;

(4) a statement describing the SERP's appeals procedures, the right to obtain information about such procedures, a statement of the claimant's right to file a civil action under section 502 of ERISA including a description of any applicable contractual limitations period that applies to the claimant's right to bring such action, including the date on which the contractual limitations period expires for the claim;

(5) a discussion of the appeal decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the SERP of health care professionals treating the claimant and the vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the SERP in connection with the claimant's appeal, without regard to whether the advice was relied on in denying the appeal, and (iii) a disability determination regarding the claimant presented by the claimant to the SERP made by the Social Security Administration;

(6) if the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial on appeal, applying the terms of the SERP to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the SERP relied upon in denying the appeal or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

7.7 Arbitration. In the event the claims review procedure described in Section 7.6 of the SERP regarding non-Disability claims does not result in an outcome thought by the claimant to be in accordance with the SERP document, he may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within sixty (60) days after receiving the RPAC's denial or deemed denial of his request for review and before bringing suit in court. The arbitration will be conducted pursuant to the American Arbitration Association (" **AAA** ") Rules on Employee Benefit Claims.

The arbitrator will be mutually selected by the claimant and the RPAC from a list of arbitrators who are experienced in nonqualified deferred compensation plan benefit matters that is provided by the AAA. If the parties are unable to agree on the selection of an arbitrator within ten (10) days of receiving the list from the AAA, the AAA will appoint an arbitrator. The arbitrator's review will be limited to interpretation of the SERP document in the context of the particular facts involved. The claimant, 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 claimant, 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 claimant or witness costs for the claimant will be borne by the claimant; provided, that, (i) if the claimant prevails in such arbitration, the Company will reimburse the claimant for his reasonable legal fees and expenses incurred in bringing the arbitration, and (ii) in all other cases, as part of his award, the Arbitrator may require the Company to reimburse the claimant for all or a portion of such amounts.

The following discovery may be conducted by the parties: interrogatories, demands to produce documents, requests for admissions and oral depositions. The arbitrator will resolve any discovery disputes by such pre hearing conferences as may be needed. The Company, RPAC and claimant agree that the arbitrator will have the power of subpoena process as provided by law. Disagreements concerning the scope of depositions or document production, its reasonableness and enforcement of discovery requests will be subject to agreement by the Company and the claimant or will be resolved by the arbitrator. All discovery requests will be subject to the proprietary rights and rights of privilege and other protections granted by applicable law to the Company and the claimant and the arbitrator will adopt procedures to protect such rights. With respect to any dispute, the Company, RPAC and the claimant agree that all discovery activities will be expressly limited to matters directly relevant to the dispute and the arbitrator will be required to fully enforce this requirement.

The arbitrator will have no power to add to, subtract from, or modify any of the terms of the SERP, or to change or add to any benefits provided by the SERP, or to waive or fail to apply any requirements of eligibility for a benefit under the SERP. Nonetheless, the arbitrator will have absolute discretion in the exercise of its powers in this SERP. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the SERP.

7.8 Receipt and Release of Necessary Information. In implementing the terms of this SERP, the RPAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the RPAC or Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this SERP will furnish to the RPAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

7.9 Overpayment and Underpayment of Benefits. The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Participant, Surviving Spouse or Eligible Child receives an underpayment of benefits, the Plan Administrator will direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Participant, Surviving Spouse or Eligible Child, for whatever reason, the Plan Administrator may, in its sole and absolute discretion, (a) withhold payment of any further benefits under the SERP until the overpayment has been collected provided that the entire amount of reduction in any calendar year does not exceed five thousand dollars ($5,000), and the reduction is made at the same time and in the same amount as the debt otherwise would have been due and collected from the Participant or (b) may require repayment of benefits paid under this SERP without regard to further benefits to which the Participant, Surviving Spouse or Eligible Child may be entitled.

7.10 Change of Control. Upon a Change of Control and for the following three (3) years thereafter, if any arbitration arises relating to an event occurring or a claim made within three (3) years of a Change of Control, (i) the arbitrator will not decide the claim based on an abuse of discretion principle or give the previous RPAC decision any special deference, but rather will determine the claim de novo based on its own independent reading of the SERP; and (ii) the Company will pay the Participant's reasonable legal and other related fees and expenses by applying Section 3.1(f) of the ESP (except that if the Participant is not entitled to severance benefits under the ESP on account of the Termination of Employment that entitles the Participant to receive

benefits under this SERP, the reference to the "shorter of the Severance Period or the Reimbursement Period" in the ESP will be changed to the "Reimbursement Period" only).

End of Article VII

ARTICLE VIII
AMENDMENT AND TERMINATION OF THE PLAN

8.1 Continuation. The Company intends to continue this SERP indefinitely, but nevertheless assumes no contractual obligation beyond the promise to pay the benefits described in this SERP.

8.2 Amendment of SERP. Except as provided below, the Company, through an action of the Human Resources Committee, reserves the right in its sole and absolute discretion to amend this SERP in any respect at any time, except that upon or during the two (2) year period after any Change of Control of the Company, (a) SERP benefits cannot be reduced, (b) Articles VII, VIII and Section 9.1(b) of the SERP cannot be changed and (c) no prospective amendment that adversely affects the rights or obligations of a Participant may be made unless the affected Participant receives at least one (1) year's advance written notice of such amendment.

Moreover, no amendment may ever be made that retroactively reduces or diminishes the rights of a Participant to the benefits described herein that have been accrued or earned through the date of such amendment, even if a Termination of Employment has not yet occurred with respect to such Participant.

In addition to the Human Resources Committee, the RPAC has the right to make non-material amendments to the SERP to comply with changes in the law or to facilitate SERP administration; provided, however, that each such proposed nonmaterial amendment must be discussed with the Chairperson of the Human Resources Committee in order to determine whether such change would constitute a material amendment to the SERP.

The provisions of this Section 8.2 will not restrict the right of the Company to terminate this SERP under Section 8.3 below or the termination of an Affiliate's participation under Section 8.4 below.

8.3 Termination of SERP. Except upon or during the two (2) year period after any Change of Control of the Company, the Company, through an action of the Human Resources Committee, may terminate or suspend this SERP in whole or in part at any time or may terminate an Agreement with any Participant at any time. In the event of termination of the SERP or of a Participant's Agreement, a Participant will be entitled to only the vested portion of his accrued benefits under Article IV of the SERP as of the time of the termination of the SERP or his Agreement. All further vesting and benefit accrual will cease on the date of SERP or Agreement termination. Benefit payments would be in the amounts specified and would commence at the time specified in Article IV as appropriate.

Notwithstanding the foregoing, the Human Resources Committee may decide to terminate and liquidate the SERP under the following circumstances:

(a) **Corporate Dissolution or Bankruptcy** . The Human Resources Committee may terminate and liquidate the SERP within twelve (12) months of a corporate dissolution taxed under section 331 of the Code or with the approval of a bankruptcy court pursuant to 11 U.S.C. § 503(b)(1)(A), provided that the amounts deferred under the SERP are included in Participants' gross income in the latest of the following years (or if earlier, the taxable year in which the amount is actually or constructively received):

(i) The calendar year in which the SERP termination and liquidation occurs.

(ii) The first calendar year in which the amount is no longer subject to a substantial risk of forfeiture.

(iii) The first calendar year in which the payment is administratively practicable.

(b) **Change of Control** . The Human Resources Committee may terminate and liquidate the SERP within the thirty (30) days preceding a Change of Control (except on account of a liquidation or dissolution of the Company) provided that all plans or arrangements that would be aggregated with the SERP under section 409A of the Code are also terminated and liquidated with respect to each Participant that experienced the Change of Control event so that under the terms of the SERP and all such arrangements the Participant is required to receive all amounts of compensation deferred under such arrangements within twelve (12) months of the termination of the SERP or arrangement, as applicable. In the case of a Change of Control event which constitutes a sale of assets, the termination of the SERP pursuant to this Section 8.3(b) may be made with respect to the Employer that is primarily liable immediately after the Change of Control transaction for the payment of benefits under the SERP.

(c) **Termination of SERP** . Except upon or during the two (2) year period after any Change of Control of the Company, the Human Resources Committee may terminate and liquidate the SERP provided that (i) the termination and liquidation does not occur by reason of a downturn of the financial health of the Company or an Employer, (ii) all plans or arrangements that would be aggregated with the SERP under section 409A of the Code are also terminated and liquidated, (iii) no payments in liquidation of the SERP are made within twelve (12) months of the date of termination of the SERP other than payments that would be made in the ordinary course operation of the SERP, (iv) all payments are made within twenty-four (24) months of the date the SERP is terminated and (v) the Company or the Employer, as applicable depending on whether the SERP is terminated with respect to such entity, do not adopt a new plan that would be aggregated with the SERP within three (3) years of the date of the termination of the SERP.

8.4 Termination of Affiliate's Participation. An Affiliate may terminate its participation in the SERP at any time by an action of its governing body and providing written notice to the Company. Likewise, the Company may terminate an Affiliate's participation in the SERP at any time by an action of the Human Resources Committee and providing written notice to the Affiliate. The effective date of any such termination will be the later of the date specified in the notice of the termination of participation or the date on which the RPAC can administratively implement such termination. In the event that an Affiliate's participation in the SERP is terminated, each Participant employed by such Affiliate will continue to participate in the SERP as an inactive Participant and will be entitled to a distribution of his vested Retirement Benefit pursuant to Article IV. An Affiliate's participation in the SERP may not be terminated upon the occurrence of or during the two (2) year period after any Change of Control.

End of Article VIII

ARTICLE IX
CONDITIONS RELATED TO BENEFITS

9.1 No Right to Assets.

(a) **SERP Unfunded** . A Participant will have only an unsecured contractual right to the amounts, if any, payable under this SERP. Neither a Participant nor any other person will acquire by reason of the SERP any right in or title to any assets, funds or property of the Employer whatsoever including, without limiting the generality of the foregoing, any specific funds or assets which the Employer, in its sole discretion, may set aside in anticipation of a liability under this SERP. Any rights created under the SERP and this Agreement will be mere unsecured contractual rights of SERP participants and their beneficiaries against Employer. The fact that the Trust has been established, to assist in the payment of benefits under this SERP will not create any preferred claim by Participants or their beneficiaries on, or any beneficial ownership interest in, any assets of the Trust. The assets of the Trust and the Employer will be subject to the claims of the Employer's general creditors under federal and state law.

(b) **Rabbi Trust** . Upon a Change of Control, the following will occur:

(i) the Trust will become (or continue to be) irrevocable;

(ii) for ten (10) years following a Change of Control, the Trustee can only be removed as set forth in the Trust;

(iii) if the Trustee is removed or resigns within ten (10) years following a Change of Control, the Trustee will select a successor Trustee as set forth in the Trust;

(iv) for three (3) years following a Change of Control, the Company will be responsible for directly paying all Trustee fees and expenses, together with all fees and expenses incurred under Article VII relating to the RPAC, Plan Administrator, and SERP administrative expenses; and

(v) any amendments to the Trust Agreement will be subject to the following restrictions: (i) certain Trust Agreement provisions may not be amended for ten (10) years following a Change of Control, as set forth in the Trust; and (ii) no such amendment will (A) change the irrevocable nature of the Trust; (B) adversely affect a Participant's rights to Retirement Benefits without the consent of the Participant; (C) impair the rights of the Company's creditors under the Trust; or (D) cause the Trust to fail to be a "grantor trust" pursuant to Code sections 671 through 679.

9.2 No Employment Rights. Nothing in this SERP will constitute a contract of continuing Employment or in any manner obligate the Employer or an Affiliate to continue the service of a Participant, or obligate a Participant to continue in the service of the Employer, and nothing in this SERP will be construed as fixing or regulating the compensation paid to a Participant.

9.3 Indebtedness. If at the time payments or installments of payments are to be made hereunder, any Participant or his Surviving Spouse or both are indebted to the Employer or an

Affiliate, then the payments remaining to be made to the Participant or his Surviving Spouse or both may, at the discretion of the RPAC, be reduced by the amount of such indebtedness; provided, that the entire amount of reduction in any calendar year does not exceed five thousand dollars ($5,000), and the reduction is made at the same time and in the same amount as the debt otherwise would have been due and collected from the Participant. An election by the RPAC not to reduce any such payment or payments will not constitute a waiver of any claim for such indebtedness.

9.4 Conditions Precedent. No Retirement Benefits will be payable hereunder to any Participant:

(a) whose Employment with the Employer or an Affiliate, is terminated for Cause; or

(b) except as provided in Sections 4.9(a)(i) and 4.9(a)(ii), who within three (3) years after Termination of Employment becomes an employee with or consultant to any third party engaged in any line of business in competition with the Employer or, to the extent determined by the Senior Vice President, Human Resources or Plan Administrator, an Affiliate (i) in a line of business in which Participant has performed services for the Employer or such Affiliate, or (ii) that accounts for more than ten percent (10%) of the gross revenues of the Employer or such Affiliate taken as a whole.

End of Article IX

ARTICLE X
MISCELLANEOUS

10.1 Gender and Number. Wherever appropriate herein, the masculine may mean the feminine and the singular may mean the plural or vice versa.

10.2 Notice. Any notice or filing required to be given or delivered to the RPAC or Plan Administrator will include delivery to or filing with a person or persons designated by the RPAC or Plan Administrator, as applicable, for the disbursement and the receipt of administrative forms. Delivery will be deemed to have occurred only when the form or other communication is actually received. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of this SERP.

10.3 Validity. In the event any provision of this SERP is held invalid, void or unenforceable, the same will not affect, in any respect whatsoever, the validity of any other provision of this SERP.

10.4 Applicable Law. This SERP will be governed and construed in accordance with the laws of the State of Texas.

10.5 Successors in Interest. This SERP will inure to the benefit of, be binding upon, and be enforceable by, any corporate successor to the Company or successor to substantially all of the assets of the Company.

10.6 No Representation on Tax Matters. The Company makes no representation to Participants regarding current or future income tax ramifications of the SERP.

10.7 Provisions Binding. All of the provisions of this SERP will be binding upon all persons who will be entitled to any benefit hereunder, their heirs and personal representatives.

End of Article X

IN WITNESS WHEREOF , this Tenth Amended and Restated Tenet Healthcare Corporation Supplemental Executive Retirement Plan has been executed this 5th day of March , 2018, effective as of April 1, 2018, except as specifically provided otherwise herein.

TENET HEALTHCARE CORPORATION

By: /s/ Paul Slavin

Paul Slavin, Vice President, Total Rewards and Workforce Analytics

EXHIBIT A1
TENET HEALTHCARE CORPORATION
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN AGREEMENT
FOR PARTICIPANTS NAMED ON AND AFTER AUGUST 3, 2011- AMI SERP BENEFITS

THIS AGREEMENT is made as of _____, _____ and supersedes [any previous agreement] [the previous agreement dated _____, _____,] by and between **TENET HEALTHCARE CORPORATION** , a Nevada corporation (" **Tenet** "), and _____ (" **Participant** ").

WHEREAS , Tenet has adopted the Tenet Healthcare Corporation Supplemental Executive Retirement Plan (the " **Tenet SERP** ") for a select group of highly compensated or management employees of Tenet and its Subsidiaries (as defined in the Tenet SERP); and

WHEREAS , Tenet has determined that Participant is currently eligible to participate in the Tenet SERP;

WHEREAS , the Tenet SERP requires that an agreement be entered into between Tenet and Participant setting out certain terms and benefits of the SERP as they apply to the Participant;

WHEREAS , Participant has also been a participant in the American Medical International, Inc. Supplemental Executive Retirement Plan (the " **AMI SERP** ") and the American Medical International, Inc. Pension Plan (the " **AMI Pension Plan** ") and has a frozen benefit under both plans as of December 31, 1995; and

WHEREAS , the amount of the benefits payable to Participant under the Tenet SERP will be reduced or offset by the benefits payable to Participant under the AMI SERP and the AMI Pension Plan.

NOW, THEREFORE , Tenet and Participant hereby agree as follows:

1. **Calculation of Benefits** . The Tenet SERP is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties will be bound by and have the benefit of each and every provision of the Tenet SERP, as amended from time to time, **EXCEPT** that when benefits become payable under the Tenet SERP, the amount of benefits calculated under the Tenet SERP will include an offset of the benefits earned under the AMI SERP and AMI Pension Plan as of December 31, 1995, in addition to offset provided by the Retirement Benefits Adjustment Factor shown in item 3 below. For purposes of determining the offset attributable to the AMI SERP and the AMI Pension Plan, the amount of Participant's benefits under the Tenet SERP, the AMI SERP and the AMI Pension Plan will be calculated as of Participant's normal retirement date, as defined in such plans, and the offset will be determined accordingly using the actuarial factors and assumptions specified in the applicable plans.

   In addition, the provisions of Section 2.20 regarding the crediting of age and Years of Service during the severance period under the Severance Plan will not apply (*i.e.* , the Participant will not be credited with age and Years of Service during the severance period and instead his eligibility for an Early Retirement Benefit will be determined as of the date of his Termination of Employment). The parties will be bound by and have the benefit of each and every applicable provision of the Tenet SERP. Participant's benefits under the AMI SERP and AMI Pension Plan will be paid to Participant pursuant to the terms of such plans.

Participant's benefits under the Tenet SERP, as calculated pursuant to this item 1, will be paid in accordance with the terms of the Tenet SERP and this Agreement.

2. **Participant Data for Benefit Calculation Purposes** . Participant was born on_____, and his or her present employment with Tenet or an Employer, (i) for purposes of determining "Years of Service," under the Tenet SERP began on _____, (ii) for purposes of determining vesting under Section 4.3 of the Tenet SERP began on _____. [In addition, Participant will be credited with [earnings for Final Average Earnings purposes] [age and service for vesting purposes] for his employment with _____ who is an Affiliate who has not adopted the SERP as an Employer.]

A " **Domestic Partner** ," as defined under the Criteria for Domestic Partnership Status under the Tenet Employee Benefit Plan, will be treated as the Participant's spouse for purposes of the Tenet SERP.

Participant's spouse/Domestic Partner (please circle which applies):

_____ was born on _____.

Participant's Eligible Children under the age of 21 and their dates of birth are as follows:

Name	**Birth Date**

Participant agrees to notify the Vice President, Compensation, Benefits and Corporate HR of Tenet promptly from time to time of any change in his or her spouse, Domestic Partner or Eligible Children.

3. **Retirement Benefit Plans Adjustment Factor** . Participant's "Retirement Benefit Plans Adjustment Factor" under Article II of the Tenet SERP as of the date of this Agreement is _____ percent. The Retirement Benefit Plans Adjustment Factor will be recalculated each year and may differ from the percent set forth in this item 3.

4. **Payment of Tenet SERP Benefits** . Except as provided in the SERP, payments under the Tenet SERP will begin not later than the first day of the calendar month following the occurrence of an event which entitles Participant (or his or her Surviving Spouse (including a Domestic Partner pursuant to item 2 herein) or Eligible Children) to payments under the Tenet SERP. Any benefits payable to a Participant by reason of a Termination of Employment will be subject to the six (6) month delay applicable to Key Employees.

5. **Dispute Resolution** . Any dispute or claim for benefits under the Tenet SERP must be resolved through the claims procedure set forth in Article VII of the Tenet SERP which procedure culminates in binding arbitration. By accepting the benefits provided under the

Tenet SERP, Participant hereby agrees to binding arbitration as the final means of dispute resolution with respect to the Tenet SERP.

6. **Successors and Assigns** . This Agreement will inure to the benefit of and be binding upon Tenet and its successors and assigns and Participant and his or her beneficiaries.

IN WITNESS WHEREOF , the parties hereto have entered into this Agreement on _____, 20__.

PARTICIPANT

_____

TENET HEALTHCARE CORPORATION

By: _____

Senior Vice President, Human Resources

EXHIBIT A2
TENET HEALTHCARE CORPORATION
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN AGREEMENT
FOR PARTICIPANTS NAMED ON AND AFTER AUGUST 3, 2011

THIS AGREEMENT is made as of _____, _____ [and supersedes] [any previous agreement] [the previous agreement dated _____, _____,] by and between **TENET HEALTHCARE CORPORATION** , a Nevada corporation (" **Tenet** "), and _____ (" **Participant** ").

WHEREAS , Tenet has adopted the Tenet Healthcare Corporation Supplemental Executive Retirement Plan (the " **Tenet SERP** ") for a select group of highly compensated or management employees of Tenet and its Subsidiaries (as defined in the Tenet SERP); and

WHEREAS , Tenet has determined that Participant is currently eligible to participate in the Tenet SERP; and

WHEREAS , the Tenet SERP requires that an agreement be entered into between Tenet and Participant setting out certain terms and benefits of the SERP as they apply to the Participant.

NOW, THEREFORE , Tenet and Participant hereby agree as follows:

1. **Incorporation of Tenet SERP Terms** . The Tenet SERP is hereby incorporated into and made a part of this Agreement as though set forth in full herein; provided, however, that the provisions of Section 2.20 regarding the crediting of age and Years of Service during the severance period under the Severance Plan will not apply (*i.e.* , the Participant will not be credited with age and Years of Service during the severance period and instead his eligibility for an Early Retirement Benefit will be determined as of the date of his Termination of Employment). The parties will be bound by and have the benefit of each and every applicable provision of the Tenet SERP. Participant's benefits under the Tenet SERP will be calculated and paid pursuant to the terms of the Tenet SERP and this Agreement.

2. **Participant Data for Benefit Calculation Purposes** . Participant was born on_____, and his or her present employment with Tenet or an Employer, (i) for purposes of determining "Years of Service," under the Tenet SERP began on _____, (ii) for purposes of determining vesting under Section 4.3 of the Tenet SERP began on _____. [In addition, Participant will be credited with [earnings for Final Average Earnings purposes] [age and service for vesting purposes] for his employment with _____ who is an Affiliate who has not adopted the SERP as an Employer.]

   A " **Domestic Partner** ," as defined under the Criteria for Domestic Partnership Status under the Tenet Employee Benefit Plan, will be treated as the Participant's spouse for purposes of the Tenet SERP.

   Participant's spouse/Domestic Partner (please circle which applies):

   _____ was born on _____.

Participant's Eligible Children under the age of 21 and their dates of birth are as follows:

Name	**Birth Date**

Participant agrees to notify the Vice President, Compensation, Benefits and Corporate HR of Tenet promptly from time to time of any change in his or her spouse, Domestic Partner or Eligible Children.

3. **Retirement Benefit Plans Adjustment Factor** . Participant's "Retirement Benefit Plans Adjustment Factor" under Article II of the Tenet SERP as of the date of this Agreement is _____ percent. The Retirement Benefit Plans Adjustment Factor will be recalculated each year and may differ from the percent set forth in this item 3.

4. **Payment of Tenet SERP Benefits** . Except as provided in the SERP, payments under the Tenet SERP will begin not later than the first day of the calendar month following the occurrence of an event which entitles Participant (or his or her Surviving Spouse (including a Domestic Partner pursuant to item 2 herein) or Eligible Children) to payments under the Tenet SERP. Any benefits payable to a Participant by reason of a Termination of Employment will be subject to the six (6) month delay applicable to Key Employees.

5. **Dispute Resolution** . Any dispute or claim for benefits under the Tenet SERP must be resolved through the claims procedure set forth in Article VII of the Tenet SERP which procedure culminates in binding arbitration. By accepting the benefits provided under the Tenet SERP, Participant hereby agrees to binding arbitration as the final means of dispute resolution with respect to the Tenet SERP.

6. **Successors and Assigns** . This Agreement will inure to the benefit of and be binding upon Tenet and its successors and assigns and Participant and his or her beneficiaries.

IN WITNESS WHEREOF , the parties hereto have entered into this Agreement on _____, 20__.

PARTICIPANT	**TENET HEALTHCARE CORPORATION**
	By:
_____	_____
	Senior Vice President, Human Resources

EXHIBIT B
UPDATE TO TENET HEALTHCARE CORPORATION
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN
AGREEMENT WITH PARTICIPANT

[This Update is to be provided and apply to each Active Participant who has an existing Agreement on December 31, 2013]

THIS UPDATE (" **Update** ") amends the Agreement (" **Agreement** ") previously entered into between _____ (" **Participant** ") and Tenet Healthcare Corporation (" **Tenet** ") with respect to Participant's benefits under the Tenet Healthcare Corporation Supplemental Executive Retirement Plan (the " **SERP** "). Capitalized terms used in this Update that are not defined herein or in Participant's Agreement will have the meaning set forth in the SERP.

1. Tenet recently updated the SERP provisions regarding calculation of the Existing Retirement Benefit Plans Adjustment Factor to provide for the annual calculation of such factor using a projection of the benefits payable to participants under the Social Security regulations and Retirement Plans in effect at the time the benefit calculation is performed. Further, for purposes of determining a participant's benefits under the Retirement Plans, the projected benefit will be measured from the participant's date of hire. In connection with this update, the name of such factor was changed to the "Retirement Benefit Plans Adjustment Factor."

2. In order to avoid any reduction in Participant’s benefits accrued under the SERP as of December 31, 2013 application of the updated calculation will be done on a grandfathered basis so that the factor will never be greater (but could be less) than the Existing Retirement Benefit Plans Adjustment Factor set forth in Participant’s Agreement.

3. The provisions of this Update are effective December 31, 2013. In all other respects the terms of Participant’s Agreement remain in effect.

Exhibit 10(ee)

TENET

FIFTH AMENDED AND RESTATED

TENET 2006 DEFERRED

COMPENSATION

PLAN

As Amended and Restated Effective as of January 1, 2019

FIFTH AMENDED AND RESTATED
TENET 2006 DEFERRED COMPENSATION PLAN

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EXHIBIT A LIMITS ON ELIGIBILITY AND PARTICIPATION A-1

FIFTH AMENDED AND RESTATED
TENET 2006 DEFERRED COMPENSATION PLAN

ARTICLE I
PREAMBLE AND PURPOSE

1.1 **Preamble.** Tenet Healthcare Corporation (the " **Company** ") previously adopted the Tenet 2006 Deferred Compensation Plan (the " **Plan** ") to permit the Company and its participating Affiliates, as defined herein (collectively, the " **Employer** "), to attract and retain a select group of management or highly compensated employees and Directors, as defined herein. The Plan replaced the Tenet 2001 Deferred Compensation Plan (the " **2001 DCP** ") and compensation and bonus deferrals and employer contributions made to the 2001 DCP during the 2005 Plan Year (*i.e.* , January 1, through December 31) were transferred to the Plan and will be administered pursuant to its terms.

Pursuant to the First Amended and Restated Plan, the Company amended and restated the Plan effective December 31, 2008 to (a) reflect that compensation and bonus deferrals and employer contributions made to the 2001 DCP have been transferred to the Plan and will be administered pursuant to its terms, (b) permit participants to elect before December 31, 2008 pursuant to transition relief issued under section 409A of the Internal Revenue Code of 1986, as amended (the " **Code** ") to receive an in-service withdrawal of amounts deemed invested in stock units in 2009 or a subsequent year, (c) modify the fixed return investment option to provide that interest will be credited based on one hundred and twenty percent (120%) of the long-term applicable federal rate as opposed to the current provision which credits interest based on the prime rate of interest less one percent (1%), (d) reduce the employer matching contribution effective January 1, 2009, (e) comply with final regulations issued under section 409A of the Code and (f) make certain other design changes. This amended and restated Plan was known as the First Amended and Restated Tenet 2006 Deferred Compensation Plan.

The Company further amended the Plan, through the adoption of the Second Amended and Restated Plan, effective as of May 9, 2012, to add certain Change of Control provisions and revise certain termination event definitions.

The Company amended and restated the Plan to increase the employer matching contribution under the Plan to conform with the matching contribution provided under the Company's tax-qualified section 401(k) plan and to incorporate certain administrative changes adopted with respect to the Plan since its prior restatement. That amended and restated Plan was known as the Third Amended and Restated Tenet 2006 Deferred Compensation Plan.

The Retirement Plans Administration Committee (" **RPAC** ") subsequently amended the Plan effective January 1, 2015 to provide that an "Affiliate" will be determined based on an ownership percentage of greater than fifty percent (50%).

The RPAC again amended and restated the Plan effective November 30, 2015 to incorporate the terms of its prior amendment, clarify that only physicians and A-Team members that provide services to Baptist Health Centers LLC (" **BHC** ") and are paid from a Tenet payroll will be eligible to participate in the Plan and reflect that the name of the Compensation Committee has changed to the " **Human Resources Committee** ." Such

amended and restated Plan was known as the Fourth Amended and Restated Tenet 2006 Deferred Compensation Plan.

By this instrument, the RPAC desires to amend and restate the Plan effective January 1, 2019, to remove reaching the compensation limit on elective deferrals under the Company's tax-qualified section 401(k) plan as a trigger that allows participation in the Plan and to authorize BHC to be a participating employer in the Plan with respect to its physician employees. This amended and restated Plan will be known as the Fifth Amended and Restated Tenet 2006 Deferred Compensation Plan.

The Employer may adopt one or more domestic trusts to serve as a possible source of funds for the payment of benefits under this Plan.

1.2 **Purpose.** Through this Plan, the Employer intends to permit the deferral of compensation and to provide additional benefits to Directors and a select group of management or highly compensated employees of the Employer. Accordingly, it is intended that this Plan will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Code, nor will it constitute a "funded plan," for purposes of such requirements. It also is intended that this Plan will be exempt from the participation and vesting requirements of Part 2 of Title I of the Employee Retirement Income Security Act of 1974, as amended (the " **Act** "), the funding requirements of Part 3 of Title I of the Act, and the fiduciary requirements of Part 4 of Title I of the Act by reason of the exclusions afforded plans that are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.1 Definitions. When a word or phrase appears in this Plan with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) " **Account** " means one or more of the bookkeeping accounts maintained by the Company or its agent on behalf of a Participant, as described in more detail in Section 4.5. A Participant's Account may be divided into one or more " **Cash Accounts** " or " **Stock Unit Accounts** " as defined in Section 4.5.

(b) " **Act** " means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(c) " **Affiliate** " means a corporation that is a member of a controlled group of corporations (as defined in section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is in common control (as defined in section 414(c) of the Code) with the Company, or any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company; provided, however that for purposes of determining if an entity is an Affiliate under sections 414(b) or (c) of the Code ownership will be determined based on an ownership percentage of greater than fifty percent (50%).

(d) " **Alternate Payee** " means any spouse, former spouse, child, or other dependent of a Participant who is recognized by a DRO as having a right to receive all, or a portion of, the benefits payable under the Plan with respect to such Participant.

(e) " **Annual Incentive Plan Award** " means the amount payable to an employee each year, if any, under the Company's Annual Incentive Plan, as the same may be amended, restated, modified, renewed or replaced from time to time.

(f) " **Base Deferral** " means the Compensation deferral made by a Participant pursuant to Section 4.2(a).

(g) " **Base with Match Deferral** " means the Base with Match Deferral made pursuant to Section 4.2(c).

(h) " **Beneficiary** " means the person designated by the Participant to receive a distribution of his benefits under the Plan upon the death of the Participant. If the Participant is married, his spouse will be his Beneficiary, unless his spouse consents in writing to the designation of an alternate Beneficiary. In the event that a Participant fails to designate a Beneficiary, or if the Participant's Beneficiary does not survive the Participant, the Participant's Beneficiary will be his surviving spouse, if any, or if the Participant does not have a surviving spouse, his estate. The term "Beneficiary" also will mean a Participant's spouse or former spouse who is entitled to all or a

portion of a Participant's benefit pursuant to Section 6.1. For this purpose a spouse means a legal spouse, including a same sex spouse.

(i) " **Board** " means the Board of Directors of the Company.

(j) " **Bonus** " means (i) a bonus paid to a Participant in the form of an Annual Incentive Plan award, (ii) a performance-based bonus payment to a Participant pursuant to an employment or similar agreement, or (iii) any other bonus payment designated by the RPAC as an eligible bonus under the Plan. As of the Effective Date, the quarterly bonuses paid to physician Employees of BHC will be an eligible bonus under the Plan.

(k) " **Bonus Deferral** " means the Bonus deferral made by a Participant pursuant to Section 4.2(b). A Participant may also defer a portion of his Bonus as a Bonus with Match Deferral pursuant to Section 4.2(c).

(l) " **Bonus with Match Deferral** " means the Bonus with Match Deferral made pursuant to Section 4.2(d).

(m) " **Cause** " means

(i) with respect to any event not occurring on or within two (2) years after a Change of Control, except as provided otherwise in a separate severance agreement or plan in which the Participant participates:

(A) dishonesty,

(B) fraud,

(C) willful misconduct,

(D) breach of fiduciary duty,

(E) conflict of interest,

(F) commission of a felony,

(G) material failure or refusal to perform his job duties in accordance with Company policies,

(H) a material violation of Company policy that causes harm to the Company or an Affiliate, or

(I) other wrongful conduct of a similar nature and degree.

A failure to meet or achieve business objectives, as defined by the Company, will not be considered Cause so long as the Participant has devoted his best efforts and attention to the achievement of those objectives.

(ii) With respect to any event occurring on or within two (2) years after a Change of Control, except as provided otherwise in a separate severance agreement or plan in which the Participant participates:

(A) any intentional act or misconduct materially injurious to the Company or any Affiliate, financial or otherwise, but not limited to, misappropriation or fraud, embezzlement or conversion by the Participant of the Company's or any Affiliate's property in connection with the Participant's employment with the Company or an Affiliate,

(B) Any willful act or omission constituting a material breach by the Participant of a fiduciary duty,

(C) A final, non-appealable order in a proceeding before a court of competent jurisdiction or a final order in an administrative proceeding finding that the Participant committed any willful misconduct or criminal activity (excluding minor traffic violations or other minor offenses), which commission is materially inimical to the interests of the Company or any Affiliate, whether for his personal benefit or in connection with his duties for the Company or an Affiliate,

(D) The conviction (or plea of no contest) of the Participant for any felony,

(E) Material failure or refusal to perform his job duties in accordance with Company policies (other than resulting from the Participant's disability as defined by Company policies), or

(F) A material violation of Company policy that causes material harm to the Company or an Affiliate.

A failure to meet or achieve business objectives, as defined by the Company, will not be considered Cause so long as the Participant has devoted his reasonable efforts and attention to the achievement of those objectives. For purposes of this Section, no act or failure to act on the part of the Participant will be deemed "willful", "intentional" or "knowing" if it was undertaken in reasonable reliance on the advice of counsel or at the instruction of the Company, including but not limited to the Board, a committee of the Board or the Chief Executive Officer (" **CEO** ") of the Company, or was due primarily to an error in judgment or negligence, but will be deemed "willful", "intentional" or "knowing" only if done or omitted to be done by the Participant not in good faith and without reasonable belief that the Participant's action or omission was in the best interest of the Company.

(iii) A Participant will not be deemed to have been terminated for Cause, under either this Section 2.1(m)(i) or 2.1(m)(ii) above, as applicable, unless and until there has been delivered to the Participant written notice that the Participant has engaged in conduct constituting Cause. The determination of Cause will be made by the Human Resources Committee with respect to any Participant who is employed as the CEO, by the CEO (or an individual acting in such capacity or possessing such authority on an interim basis)

with respect to any other Participant except a Hospital Chief Executive Officer (" **Hospital CEO** ") and by the Chief Operating Officer of the Company (the " **COO** ") with respect to any Participant who is employed as a Hospital CEO. A Participant who receives written notice that he has engaged in conduct constituting Cause, will be given the opportunity to be heard (either in person or in writing as mutually agreed to by the Participant and the Human Resources Committee, CEO or COO, as applicable) for the purpose of considering whether Cause exists. If it is determined either at or following such hearing that Cause exists, the Participant will be notified in writing of such determination within five (5) business days. If the Participant disagrees with such determination, the Participant may file a claim contesting such determination pursuant to Article VIII within thirty (30) days after his receipt of such written determination finding that Cause exists.

(n) " **Change of Control** " means the occurrence of one of the following:

(i) A "change in the ownership of the Company" which will occur on the date that any one person, or more than one person acting as a group within the meaning of section 409A of the Code, acquires, directly or indirectly, whether in a single transaction or series of related transactions, ownership of stock in the Company that, together with stock held by such person or group, constitutes more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company (" **Ownership Control** "). However, if any one person or more than one person acting as a group, has previously acquired ownership of more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company, the acquisition of additional stock by the same person or persons will not be considered a "change in the ownership of the Company" (or to cause a "change in the effective control of the Company" within the meaning of Section 2.1(n)(ii) below). Further, an increase in the effective percentage of stock owned by any one person, or persons acting as a group, as a result of a transaction in which the Company acquires its stock in exchange for cash or property will be treated as an acquisition of stock for purposes of this paragraph; provided, that for purposes of this Section 2.1(n)(i), the following acquisitions of Company stock will not constitute a Change of Control:

(A) any acquisition, whether in a single transaction or series of related transactions, by any employee benefit plan (or related trust) sponsored or maintained by the Company or an Affiliate which results in such employee benefit plan obtaining "Ownership Control" of the Company or

(B) any acquisition, whether in a single transaction or series of related transactions, by the Company which results in the Company acquiring stock of the Company representing "Ownership Control" or

(C) any acquisition, whether in a single transaction or series of related transactions, after which those persons who were owners of the Company's stock immediately before such transaction(s) own more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Company (or if after the consummation of such transaction(s) the Company (or another entity into which the Company is merged into or otherwise combined, such the Company does not survive such transaction(s)) is a direct or indirect subsidiary of another entity which itself is not a subsidiary of an entity, then the more than fifty percent (50%) ownership test will be applied to the voting securities of such other entity) in substantially the same percentages as their respective ownership of the Company immediately before such transaction(s).

This Section 2.1(n)(i) applies either when there is a transfer of the stock of the Company (or issuance of stock) and stock in the Company remains outstanding after the transaction or when there is a transfer of the stock of the Company (including a merger or similar transaction) and stock in the Company does not remain outstanding after the transaction .

(ii) A "change in the effective control of the Company" which will occur on the date that either (A) or (B) occurs:

(A) any one person, or more than one person acting as a group within the meaning of section 409A of the Code, acquires (taking into consideration any prior acquisitions during the twelve (12) month period ending on the date of the most recent acquisition by such person or persons), directly or indirectly, ownership of stock of the Company possessing thirty-five percent (35%) or more of the total voting power of the stock of the Company (not considering stock owned by such person or group before such twelve (12) month period) (*i.e.* , such person or group must acquire within a twelve (12) month period stock possessing at least thirty-five percent (35%) of the total voting power of the stock of the Company) (" **Effective Control** "), except for (i) any acquisition by any employee benefit plan (or related trust) sponsored or maintained by the Company or an Affiliate which results in such employee benefit plan obtaining "Effective Control" of the Company or (ii) any acquisition by the Company. The occurrence of "Effective Control" under this Section 2.1(n)(ii)(A) may be nullified by a vote of that number of the members of the Board of Directors of the Company ("Board"), that exceeds two-thirds (2/3) of the independent members of the Board, which vote must occur before the time, if any, that a "change in the effective control of the Company" has occurred under Section 2.1(n)(ii)(B) below. In the event of such a supermajority vote, such transaction or series of related transactions will not be treated as an event constituting "Effective Control". For avoidance of doubt, the Plan provides that in the event of the occurrence of the acquisition of ownership of stock of the Company that reaches or exceeds the thirty-five percent (35%) ownership threshold described above, if

more than two-thirds (2/3) of the independent members of the Board take action to resolve that such an acquisition is not a "change in the effective control of the Company" and a majority of the members of the Board have not been replaced as provided under Section 2.1(n)(ii)(B) below, then such Board action will be final and no "Effective Control" will be deemed to have occurred for any purpose under the Plan.

(B) a majority of the members of the Board are replaced during any twelve (12) month period by directors whose appointment or election is not endorsed by a majority of the members of the Board before the date of the appointment or election.

For purposes of a "change in the effective control of the Company," if any one person, or more than one person acting as a group, is considered to effectively control the Company within the meaning of this Section 2.1(n)(ii), the acquisition of additional control of the Company by the same person or persons is not considered a "change in the effective control of the Company," or to cause a "change in the ownership of the Company" within the meaning of Section 2.1(n)(i) above.

(iii) A sale, exchange, lease, disposition or other transfer of all or substantially all of the assets of the Company.

(iv) A liquidation or dissolution of the Company that is approved by a majority of the Company's stockholders.

For purposes of this Section 2.1(n), the provisions of section 318(a) of the Code regarding the constructive ownership of stock will apply to determine stock ownership; provided, that, stock underlying unvested options (including options exercisable for stock that is not substantially vested) will not be treated as owned by the individual who holds the option.

(o) " **Code** " means the Internal Revenue Code of 1986, as amended from time to time.

(p) " **Company** " means Tenet Healthcare Corporation.

(q) " **Compensation** " means base salaries, commissions, and certain other amounts of cash compensation payable to the Participant during the Plan Year, including draws paid to physician Employees of BHC. Compensation will **exclude** cash bonuses, foreign service pay, hardship withdrawal allowances and any other pay intended to reimburse the employee for the higher cost of living outside the United States, Annual Incentive Plan Awards, automobile allowances, housing allowances, relocation payments, deemed income, income payable under stock incentive plans, insurance premiums, and other imputed income, pensions, retirement benefits, and contributions to and payments from the 401(k) Plan and this Plan or any other nonqualified retirement plan maintained by the Employer. The term "Compensation" for Directors will mean any cash compensation from retainers, meeting fees and committee fees paid during the Plan Year.

(r) " **Compensation and Bonus Deferrals** " means the Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, and/or Discretionary Deferrals made pursuant to Section 4.2 of the Plan.

(s) " **Director** " means a member of the Board who is not an employee.

(t) " **Discretionary Contribution** " means the contribution made by the Employer on behalf of a Participant as described in Section 4.4(b).

(u) " **Discretionary Deferral** " means the Compensation deferral described in Section 4.2(d) made by a Participant.

(v) " **DRO** " means a domestic relations order that is a judgment, decree, or order (including one that approves a property settlement agreement) that relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of a Participant and is rendered under a state (within the meaning of section 7701(a)(10) of the Code) domestic relations law (including a community property law) and that:

(i) Creates or recognizes the existence of an Alternate Payee's right to, or assigns to an Alternate Payee the right to receive all or a portion of the benefits payable with respect to a Participant under the Plan;

(ii) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan;

(iii) Does not require the Plan to provide increased benefits (determined on the basis of actuarial value);

(iv) Does not require the payment of benefits to an Alternate Payee that are required to be paid to another Alternate Payee under another order previously determined to be a DRO; and

(v) Clearly specifies: the name and last known mailing address of the Participant and of each Alternate Payee covered by the DRO; the amount or percentage of the Participant's benefits to be paid by the Plan to each such Alternate Payee, or the manner in which such amount or percentage is to be determined; the number of payments or payment periods to which such order applies; and that it is applicable with respect to this Plan.

(w) " **Effective Date** " means January 1, 2019, except as provided otherwise herein.

(x) " **Election** " means the Participant’s written, on-line or telephonic elections with respect to deferrals, requested investment crediting rates and distributions under this Plan.

(y) " **Eligible Person** " means (i) each Employee who is paid from a Tenet payroll and eligible for a Bonus as defined in Section 2.1(j) for the applicable Plan Year, and (ii) each Director. In addition, the term "Eligible Person" will include any Employee designated as an Eligible Person by the RPAC. As provided in Section 3.1, the

RPAC or Plan Administrator may at any time, in its sole and absolute discretion, limit the classification of Employees who are eligible to participate in the Plan for a Plan Year, limit the enrollment period during which an Eligible Person may enroll in the Plan to the Open Enrollment Period and/or modify or terminate an Eligible Person's participation in the Plan through Exhibit A without the need for an amendment to the Plan.

(z) " **Employee** " means each select member of management or highly compensated employee receiving remuneration, or who is entitled to remuneration, for services rendered to the Employer, in the legal relationship of employer and employee.

(aa) " **Employer** " means the Company and each Affiliate who with the consent of the Senior Vice President, Human Resources or Plan Administrator has adopted the Plan as a participating employer. An Affiliate may evidence its adoption of the Plan either by a formal action of its governing body or by commencing deferrals and taking other administrative actions with respect to this Plan on behalf of its employees. An entity will cease to be a participating employer as of the date such entity ceases to be an Affiliate or the date specified by the Company.

(bb) " **Employer Contribution** " means a Matching Contribution and/or Discretionary Contribution.

(cc) " **Fair Market Value** " means the closing price of a share of Stock on the New York Stock Exchange on the date as of which fair market value is to be determined.

(dd) " **Five Percent Owner** " means any person who owns (or is considered as owning within the meaning of section 318 of the Code (as modified by section 416(i)(1)(B)(iii) of the Code)) more than five percent (5%) of the outstanding stock of the Company or an Affiliate or stock possessing more than five percent (5%) of the total combined voting power of all stock of the Company or an Affiliate. The rules of sections 414(b), (c) and (m) of the Code will not apply for purposes of applying these ownership rules. Thus, this ownership test will be applied separately with respect to the Company and each Affiliate.

(ee) " **401(k) Plan** " means the Company's 401(k) Retirement Savings Plan, as such plan may be amended, restated, modified, renewed or replaced from time to time.

(ff) " **Human Resources Committee** " means the Human Resources Committee of the Board (or any predecessor or successor to such committee in name or form), which has the authority to amend and terminate the Plan as provided in Article X. The Human Resources Committee also will be responsible for determining the amount of the Discretionary Contribution, if any, to be made by the Employer

(gg) " **Key Employee** " means any employee or former employee (including any deceased employee) who at any time during the Plan Year was:

(i) an officer of the Company or an Affiliate having compensation of greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code for Plan Years beginning after December 31, 2002);

(ii) a Five Percent Owner; or

(iii) a One Percent Owner having compensation of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or One Percent Owner in accordance with section 1.415(c)-2(d)(4) of the Treasury Regulations (*i.e.* , W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections) under section 132(f) of the Code (regarding qualified transportation fringe benefits) or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special timing rules and special rules set forth, respectively, in sections 1.415(c)-2(e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (*i.e.* , the identification date). Employees that are Key Employees during such twelve (12) month period will be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (*i.e.* , since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder. For purposes of determining whether an employee or former employee is an officer, a Five Percent Owner or a One Percent Owner, the Company and each Affiliate will be treated as a separate employer (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.1(gg)(i), compensation from the Company and all Affiliates will be taken into account (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.1(gg)(i), no more than fifty (50) employees of the Company or its Affiliates (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50), the determination of which employees or former employees are officers will be determined based on who had the largest annual compensation from the Company and Affiliates for the Plan Year. For the avoidance of doubt, for purposes of this Section 2.1(gg) the controlled group rules under sections 414(b) and (c) of the Code will be applied based on the normal ownership percentage of greater than eighty percent (80%) rather than the fifty percent (50%) standard used in the definition of Affiliate.

(hh) " **Matching Contribution** " means the contribution made by the Employer pursuant to Section 4.4(a) on behalf of a Participant who makes Base with Match Deferrals and/or Bonus with Match Deferrals to the Plan as described in Section 4.2(c).

(ii) " **One Percent Owner** " means any person who would be described as a Five Percent Owner if "one percent (1%)" were substituted for "five percent (5%)" each place where it appears therein.

(jj) " **Open Enrollment Period** " means the period occurring each year during which an Eligible Person may make his elections to defer his Compensation, Bonus and RSUs for a subsequent Plan Year pursuant to Article IV. Open Enrollment Periods will occur in accordance with section 409A of the Code (*i.e.* , no later than December 31st of each year with respect to Compensation, no later than June 30 of each year with respect to Bonus and either before or within thirty (30) days after the date of grant with respect to RSUs). Different Open Enrollment Periods may apply with respect to different groups of Eligible Persons. An Employee who is not an Eligible Person at the time of the Open Enrollment Period, but who is expected to become an Eligible Person during the next Plan Year, may be permitted to enroll in the Plan during the Open Enrollment Period with his Election becoming effective at the time he becomes an Eligible Person with respect to Compensation, Bonus and RSUs earned after such date.

(kk) " **Participant** " means each Eligible Person who has been designated for participation in this Plan and has made an Election and each Employee or former Employee (or Director or former Director) whose participation in this Plan has not terminated (i.e., the individual still has amounts credited to his Account).

(ll) " **Participant Deferral** " means a Base Deferral, Base with Match Deferral, Bonus Deferral, Bonus with Match Deferral, RSU Deferral and/or Discretionary Deferral.

(mm) " **Plan** " means the Fifth Amended and Restated Tenet 2006 Deferred Compensation Plan as set forth in this document and as the same may be amended from time to time.

(nn) " **Plan Administrator** " means the individual or entity appointed by the RPAC to handle the day-to-day administration of the Plan, including but not limited to determining a Participant's eligibility for benefits and the amount of such benefits and complying with all applicable reporting and disclosure obligations imposed on the Plan. If the RPAC does not appoint an individual or entity as Plan Administrator, the RPAC will serve as the Plan Administrator.

(oo) " **Plan Year** " means the fiscal year of this Plan, which will commence on January 1 each year and end on December 31 of such year.

(pp) " **RPAC** " means the Retirement Plans Administration Committee of the Company established by the Human Resources Committee of the Board, and whose members have been appointed by such Human Resources Committee. The RPAC will have the responsibility to administer the Plan and make final determinations regarding claims for benefits, as described in Article VIII. In addition, the RPAC has limited amendment authority over the Plan as provided in Section 10.2.

(qq) " **RSU Deferral** " means the RSU deferral made by a Participant pursuant to Section 4.3.

(rr) " **RSU** " means the restricted stock units awarded under the SIP.

(ss) " **Scheduled In-Service Withdrawal** " means a distribution elected by the Participant pursuant to Section 4.2 or Section 4.3 for an in-service withdrawal of amounts of Base Deferrals, Bonus Deferrals and/or RSU Deferrals made in a given Plan Year, and earnings or losses attributable to such amounts, as reflected in the Participant's Election for such Plan Year.

(tt) " **Scheduled Withdrawal Date** " means the distribution date elected by the Participant for a Scheduled In-Service Withdrawal.

(uu) " **SIP** " means the Company's Stock Incentive Plan.

(vv) " **Special Enrollment Period** " means, subject to Section 3.1(b) and Section 3.1(c), a period of no more than thirty (30) days after an Employee is employed by the Employer (or a Director is elected to the Board) or an Employee is transferred to the status of an Eligible Person provided that such Employee does not already participate in another plan of the Employer that would be aggregated with the Plan and advised of his eligibility to participate in the Plan during which the Eligible Person may make an Election to defer Compensation and RSUs earned after such Election pursuant to Article IV. If the Employee becomes an Eligible Person before June 30, he may make an Election to defer Bonus earned after such Election to the extent permitted by the Plan Administrator. For purposes of determining an Eligible Person's initial eligibility, an Eligible Person, who incurs a Termination of Employment and is reemployed and eligible to participate in the Plan at a date which is more than twenty-four (24) months after such Termination of Employment, will be treated as being initially eligible to participate in the Plan on such reemployment. The Plan Administrator may also designate certain periods as Special Enrollment Periods to the extent permitted under section 409A of the Code.

(ww) " **Stock** " means the common stock, par value $0.05 per share, of the Company.

(xx) " **Stock Unit** " means a non-voting, non-transferable unit of measurement that is deemed for bookkeeping and distribution purposes only to represent one outstanding share of Stock.

(yy) " **Termination of Employment** " means (i) with respect to an Employee, the date that such Employee ceases performing services for the Employer and its Affiliates in the capacity of an employee or a reduction in employment or other provision of services that qualifies as a separation from service under Code section 409A and (ii) with respect to a Director, the date that such Director ceases to provide services to the Company as a member of the Board or otherwise or a reduction in employment or other provision of services that qualifies as a separation from service under Code section 409A. For this purpose an Employee who is on a leave of absence that exceeds six (6) months and who does not have statutory or contractual reemployment rights with respect to such leave, will be deemed to have incurred a Termination of Employment on the first day of the seventh (7th) month of such leave. An Employee who transfers employment from an Employer to an Affiliate, regardless

of whether such Affiliate has adopted the Plan as a participating employer, will not incur a Termination of Employment.

(zz) " **Trust** " means the rabbi trust established with respect to the Plan, the assets of which are to be used for the payment of benefits under the Plan.

(aaa) " **Trustee** " means the individual or entity appointed to serve as trustee of any trust established as a possible source of funds for the payment of benefits under this Plan as provided in Section 7.1. After the occurrence of a Change of Control, the Trustee must be independent of any successor to the Company or any affiliate of such successor.

(bbb) " **2001 DCP** " means the Tenet 2001 Deferred Compensation Plan which was in effect before the enactment of section 409A of the Code. All pre-2005 employee deferrals and employer contributions under the 2001 DCP were fully vested as of January 31, 2004 and as such are not subject to the provisions of section 409A of the Code. All 2005 employee deferrals and employer contributions under the 2001 DCP are subject to, and were made in accordance with, the requirements of section 409A of the Code and such employee deferrals and employer contributions were transferred to and will be administered under this Plan. No employee deferrals or employer contributions will be made to the 2001 DCP after 2005.

(ccc) " **Unforeseeable Emergency** " means (i) a severe financial hardship to the Participant resulting from an illness or accident of the Participant, his spouse or his dependent (as defined under section 152(a) of the Code), (ii) a loss of the Participant's property due to casualty, or (iii) other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant, as determined by the Plan Administrator in its sole and absolute discretion in accordance with the requirements of section 409A of the Code.

2.2 Construction. If any provision of this Plan is determined to be for any reason invalid or unenforceable, the remaining provisions of this Plan will continue in full force and effect. All of the provisions of this Plan will be construed and enforced in accordance with the laws of the State of Texas and will be administered according to the laws of such state, except as otherwise required by the Act, the Code or other applicable federal law.

The term "delivered to the RPAC or Plan Administrator," as used in this Plan, will include delivery to a person or persons designated by the RPAC or Plan Administrator, as applicable, for the disbursement and the receipt of administrative forms. Delivery will be deemed to have occurred only when the form or other communication is actually received.

Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of this Plan. The pronouns "he," "him" and "his" used in the Plan will also refer to similar pronouns of the female gender unless otherwise qualified by the context.

End of Article II

ARTICLE III
PARTICIPATION AND FORFEITABILITY OF BENEFITS

3.1 Eligibility and Participation.

(a) **Determination of Eligibility** . It is intended that eligibility to participate in the Plan will be limited to Eligible Persons, as determined by the RPAC, in its sole and absolute discretion. During the Open Enrollment Period, each Eligible Person will be contacted and informed that he may elect to defer portions of his Compensation, Bonus and/or RSUs by making an Election. An Eligible Person will become a Participant by completing an Election during an Open Enrollment Period pursuant to Section 4.1. Eligibility to become a Participant for any Plan Year will not entitle an Eligible Person to continue as an active Participant for any subsequent Plan Year.

(b) **Limits on Eligibility** . The RPAC or Plan Administrator may at any time, in its sole and absolute discretion, limit the classification of Employees eligible to participate in the Plan and/or limit the period of such Employee's enrollment to an Open Enrollment Period and to not permit such Employee to enroll during a Special Enrollment Period. In addition, the RPAC may limit or terminate an Eligible Person's participation in the Plan; provided, that no such termination will result in a cancellation of Compensation and Bonus Deferrals or RSU Deferrals for the remainder of a Plan Year in which an Election to make such deferrals is in effect. Any action taken by the RPAC or Plan Administrator that limits the classification of Employees eligible to participate in the Plan, limits the time of an Employee's enrollment in the Plan or modifies or terminates an Eligible Person's participation in the Plan will be set forth in Exhibit A attached hereto. Exhibit A may be modified from time to time without a formal amendment to the Plan, in which case a revised Exhibit A will be attached hereto.

An Employee who takes an Unforeseeable Emergency distribution pursuant to Section 5.4 of this Plan will have his Compensation and Bonus Deferrals and RSU Deferrals under this Plan suspended for the remainder of the Plan Year in which such distribution occurs. This mid-year suspension provision will also apply with respect to an Unforeseeable Emergency distribution made pursuant to 5.4 of the 2001 DCP. In addition, an Employee who takes an Unforeseeable Emergency distribution under either the 2001 DCP or this Plan will be ineligible to participate in the Plan for purposes of making Compensation and Bonus Deferrals and RSU Deferrals and receiving a Matching Contribution for the Plan Year following the year in which such distribution occurs.

(c) **Initial Eligibility** . If an Eligible Person is employed or elected to the Board during the Plan Year or promoted or transferred into an eligible position and designated by the RPAC to be a Participant for such year, such Eligible Person will be eligible to elect to participate in the Plan during a Special Enrollment Period, unless determined otherwise by the Plan Administrator pursuant to Section 3.1(b), in which case, such Eligible Person will be permitted to enroll in the Plan during the next Open Enrollment Period. For purposes of determining an Eligible Person's initial

eligibility, an Eligible Person, who incurs a Termination of Employment and is reemployed and eligible to participate in the Plan at a date which is more than twenty-four (24) months after such Termination of Employment, will be treated as being initially eligible to participate in the Plan on such reemployment. Designation as a Participant for the Plan Year in which he is employed or elected to the Board or promoted will not entitle the Eligible Person to continue as an active Participant for any subsequent Plan Year.

(d) **Loss of Eligibility Status** . A Participant under this Plan who separates from employment with the Employer, or who ceases to be a Director, or who transfers to an ineligible employment position will continue as an inactive Participant under this Plan until the Participant has received payment of all amounts payable to him under this Plan. In the event that a Participant ceases to be an Eligible Person during the Plan Year, such Participant's Compensation and Bonus Deferrals and RSU Deferrals will continue through the remainder of the Plan Year, but the Participant will not be permitted to make such deferrals for the following Plan Year unless he again becomes an Eligible Person and makes a deferral Election pursuant to Section 3.1(a). An Eligible Person who ceases active participation in the Plan because the Eligible Person is no longer described as a Participant pursuant to this Section 3.1, or because he ceases making deferrals of Compensation, Bonuses or RSUs, will continue as an inactive Participant under this Plan until he has received payment of all amounts payable to him under this Plan. An inactive Participant will continue to have his Accounts adjusted pursuant to Section 4.6 based on his investment crediting rate elections until such Accounts have been paid in full.

3.2 Forfeitability of Benefits. Except as provided in Section 6.1, a Participant will at all times have a nonforfeitable right to amounts credited to his Account pursuant to Section 4.5. As provided in Section 7.2, however, each Participant will be only a general creditor of the Company and/or his Employer with respect to the payment of any benefit under this Plan.

End or Article III

ARTICLE IV
DEFERRAL, COMPANY CONTRIBUTIONS, ACCOUNTING AND INVESTMENT CREDITING RATES

4.1 General Rules Regarding Deferral Elections. An Eligible Person may become a Participant in the Plan for the applicable Plan Year by making an Election during the Open Enrollment Period to defer his Compensation, Bonus and/or RSUs pursuant to the terms of this Section 4.1. Such Election will be made by the date specified by the Plan Administrator and will be effective with respect to:

(a) Compensation and/or Bonus paid for services performed on or after the following January 1; and

(b) RSUs that are awarded under the SIP, either before or within thirty (30) days after the grant date as required by section 409A of the Code.

An Eligible Person who is employed by the Employer or elected to the Board during the Plan Year may make an Election during the Special Enrollment Period with respect to Compensation, Bonus and/or RSUs earned after the date of such Election to the extent permitted under Section 2.1(vv).

A Participant's Election will only be effective with respect to a single Plan Year and will be irrevocable for the duration of such Plan Year. Deferral elections for each applicable Plan Year of participation will be made during the Open Enrollment Period pursuant to a new Election. Deferrals will not be required to be taken from each paycheck during the applicable Plan Year so long as the total Compensation and Bonus elected to be deferred for the Plan Year has been captured by December 31 of such Plan Year.

4.2 Compensation and Bonus Deferrals. Five types of Compensation and Bonus Deferrals may be made under the Plan:

(a) **Base Deferral** . Each Eligible Person may elect to defer a stated dollar amount, or designated full percentage, of Compensation to the Plan up to a maximum percentage of seventy five percent (75%) (one hundred percent (100%) for Directors) of the Eligible Person's Compensation for the applicable Plan Year until either (i) the Participant's Termination of Employment or (ii) a future year in which the Participant is still employed by the Employer (or providing services as a member of the Board) and that is at least two (2) calendar years after the end of the Plan Year in which the Compensation would have otherwise been paid (*i.e.* , as a Scheduled In-Service Withdrawal subject to the provisions of Section 5.3).

Base Deferrals will be made pursuant to administrative procedures established by the Plan Administrator. Such procedures will provide that Base Deferrals will be subject to a "withholding hierarchy" for purposes of determining the amount of such contributions that may be contributed on behalf of a Participant. The Plan Administrator (or its delegatee) will determine the order of withholdings taken from a Participant's Compensation (*e.g.* , for federal, state and local taxes, social security, wage garnishments, welfare plan contributions, 401(k) deferrals, and similar withholdings) and Base Deferrals will be subject to such withholding hierarchy. As

a result, Base Deferrals may be effectively limited to Compensation available after the application of such withholding hierarchy.

The Employer will not make any Matching Contributions with respect to any Base Deferrals made to the Plan.

(b) **Bonus Deferral** . Each Eligible Person may elect to defer a stated dollar amount, or designated full percentage, of his Bonus to the Plan up to a maximum percentage of one hundred percent (100%) (ninety four percent (94%) if a Bonus with Match Deferral is elected pursuant to Section 4.2(d)) of the Employee's Bonus for the applicable Plan Year until either (i) the Eligible Person's Termination of Employment or (ii) a future year in which the Eligible Person is still employed by the Employer (or providing services as a member of the Board) and that is at least two (2) calendar years after the end of the Plan Year in which the Bonus would have otherwise been paid (*i.e.* , as a Scheduled In-Service Withdrawal subject to the provisions of Section 5.3).

Bonus Deferrals will be made pursuant to administrative procedures established by the Plan Administrator. Such procedures will provide that Bonus Deferrals will be subject to a "withholding hierarchy" for purposes of determining the amount of such contributions that may be contributed on behalf of a Participant. The Plan Administrator (or its delegatee) will determine the order of withholdings taken from a Participant's Bonus (*e.g.* , for federal, state and local taxes, social security, wage garnishments, welfare plan contributions, and similar withholdings) and Bonus Deferrals will be subject to such withholding hierarchy. As a result, Bonus Deferrals may be effectively limited to Bonus available after the application of such withholding hierarchy.

Bonus Deferrals generally will be made in the form of cash; provided, however, that if the Company modifies the Annual Incentive Plan to provide for the payment of awards in Stock, Bonus Deferrals may be made in the form of Stock. Any Bonus Deferrals made in the form of Stock will be converted to Stock Units, based on the number of shares so deferred, credited to the Stock Unit Account and distributed to the Participant at the time specified herein in an equivalent number of whole shares of Stock as provided in Section 4.5(b).

The Employer will not make any Matching Contributions with respect to any Bonus Deferrals made to the Plan.

(c) **Base with Match Deferral** . Each Eligible Person who is a participant in the 401(k) Plan may elect to have one percent (1%) to six percent (6%) of his Compensation deferred under the Plan as a Base with Match Deferral with respect to the pay period in which his deferrals to the 401(k) Plan reach the limit imposed on elective deferrals under section 402(g) of the Code, including the limit applicable to catch-up contributions to the extent the Eligible Person is eligible to make such contributions, as such limit is adjusted for cost of living increases.

All Base with Match Deferrals will be payable upon Termination of Employment (*i.e.* , Scheduled In-Service Withdrawals are not available with respect to Base with Match

Deferrals). A Participant who earns more than Four Hundred Thousand Dollars ($400,000) in Compensation (excluding Bonus), or such other amount as the Plan Administrator deems necessary to satisfy the requirements of section 409A of the Code, and elects to make Base with Match Deferrals under this Section 4.2(c) will not be permitted to modify his 401(k) Plan deferral elections during the Plan Year in which such Base with Match Deferral Election is in effect.

The Employer will make Matching Contributions with respect to Base with Match Deferrals made to the Plan as provided in Section 4.4.

(d) **Bonus with Match Deferral** . Each Eligible Person may elect to automatically have six percent (6%) of his Bonus deferred under the Plan as a Bonus with Match Deferral whether or not the Eligible Person is a participant in the 401(k) Plan or his deferrals under the 401(k) Plan have reached limit imposed on elective deferrals under section 402(g) of the Code, including the limit applicable to catch-up contributions to the extent the Eligible Person is eligible to make such contributions. This Bonus with Match Deferral will be applied to that portion of the Eligible Person's Bonus in excess of that deferred as a Bonus Deferral under Section 4.2(b). For example, if the Eligible Person elects to defer fifty percent (50%) of his Bonus under Section 4.2(b) and also elects to make a Bonus with Match Deferral under this Section 4.2(d), fifty percent (50%) of the Eligible Person's Bonus will be deferred under Section 4.2(b) and six percent (6%) of the Eligible Person's Bonus will be deferred under this Section 4.2(d). All Bonus with Match Deferrals will be payable upon Termination of Employment (*i.e.* , Scheduled In-Service Withdrawals are not available with respect to Bonus with Match Deferrals).

The Employer will make Matching Contributions with respect to Base with Match Deferrals and Bonus with Match Deferrals made to the Plan as provided in Section 4.4.

(e) **Discretionary Deferral** . The RPAC may authorize an Eligible Person to defer a stated dollar amount, or designated full percentage, of Compensation to the Plan as a Discretionary Deferral. The RPAC, in its sole and absolute discretion, may limit the amount or percentage of Compensation an Eligible Person may defer to the Plan as a Discretionary Deferral and may prohibit Scheduled In-Service Withdrawals with respect to such Discretionary Deferral. The Employer will not make any Matching Contributions pursuant to Section 4.4(a) with respect to any Discretionary Deferrals, but may elect to make a Discretionary Contribution to the Plan with respect to such Discretionary Deferrals in the form of a discretionary matching contribution as described in Section 4.4(b).

4.3 RSU Deferrals. To the extent authorized by the RPAC, an Eligible Person may make an Election to defer a designated full percentage, up to one hundred percent (100%) of his RSUs until either (a) the Eligible Person's Termination of Employment or (b) a future year while the Eligible Person is still employed by the Employer and that is at least two (2) calendar years after the end of the Plan Year in which the RSU is granted (*i.e.* , as a Scheduled In-Service Withdrawal subject to the provisions of 5.3. A deferral Election made pursuant to this Section 4.3 will apply to the entire RSU grant (*i.e.* , a Participant may not elect to make a separate Election with respect to each portion of the RSU award based on

the award's vesting schedule). Such RSU Deferrals will be converted to Stock Units, based on the number of shares so deferred, credited to the Stock Unit Account and distributed to the Participant at the time specified in his Election in an equivalent number of whole shares of Stock as provided in Section 4.5(b).

The Employer will not make any Matching Contributions with respect to any RSU Deferrals made to the Plan.

4.4 Company Contributions.

(a) **Matching Contribution** . The Employer will make a Matching Contribution to the Plan each Plan Year on behalf of each Participant who makes Base with Match Deferrals and Bonus with Match Deferrals to the Plan for such Plan Year. Such Matching Contribution will equal fifty percent (50%) of the first six percent (6%) of the Participant's Base with Match and/or six percent (6%) of the Participant's Bonus with Match Deferrals for such Plan Year. Matching Contributions and earnings and losses thereon will be distributed upon the Participant's Termination of Employment in the manner elected by the Participant (or deemed elected by the Participant) for the Plan Year to which the Matching Contribution relates as provided in Section 5.1.

(b) **Discretionary Contribution** . The Employer may elect to make a Discretionary Contribution to a Participant's Account in such amount, and at such time, as will be determined by the Human Resources Committee. Any Discretionary Contribution made by the Employer, plus earnings and losses thereon, will be paid to the Participant upon his Termination of Employment with the Employer in the manner elected by the Participant (or deemed elected by the Participant) for the Plan Year to which the Discretionary Contribution relates as provided in Section 5.1.

4.5 Accounting for Deferred Compensation.

(a) **Cash Account** . If a Participant has made an Election to defer his Compensation and/or Bonus and has made a request for amounts deferred to be deemed invested pursuant to Section 4.5(a), the Company may, in its sole and absolute discretion, establish and maintain a Cash Account for the Participant under this Plan. Each Cash Account will be adjusted at least quarterly to reflect the Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, Discretionary Deferrals, Matching Contributions and Discretionary Contributions credited thereto, earnings or losses credited thereon, and any payment of such Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, Discretionary Deferrals, Matching Contributions and Discretionary Contributions pursuant to Article V. The amounts of Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, Discretionary Deferrals and Matching Contributions will be credited to the Participant's Cash Account within five (5) business days of the date on which such Compensation and/or Bonus would have been paid to the Participant had the Participant not elected to defer such amount pursuant to the terms and provisions of the Plan. Any Discretionary Contributions will be credited to each Participant's Cash Account at such times as determined by the Human Resources Committee. In the sole and absolute discretion of the Plan Administrator, more than one Cash Account may be established for each Participant

to facilitate record-keeping convenience and accuracy. Each such Cash Account will be credited and adjusted as provided in this Plan.

(b) **Stock Unit Account** . If a Participant has made an Election to defer his Compensation and/or Bonus and has made a request for such deferrals to be deemed invested in Stock Units pursuant to Section 4.5(b), the Plan Administrator may, in its sole and absolute discretion, establish and maintain a Stock Unit Account and credit the Participant's Stock Unit Account with a number of Stock Units determined by dividing an amount equal to the Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, and associated Matching Contributions, and Discretionary Deferrals made as of such date by the Fair Market Value of a share of Stock on the date such Compensation and/or Bonus otherwise would have been payable. Such Stock Units will be credited to the Participant's Stock Unit Account as soon as administratively practicable after the determination of the number of Stock Units is made pursuant to the preceding sentence.

If the Participant is entitled to a Discretionary Contribution and has elected to have amounts credited to his Account to be deemed invested in Stock Units pursuant to Section 4.6(b), the Plan Administrator may, in its sole discretion, establish and maintain a Stock Unit Account and credit the Participant's Stock Unit Account with a number of Stock Units determined by dividing an amount equal to the Discretionary Contribution made as of such date by the Fair Market Value of a share of Stock on the date such Discretionary Contribution would have otherwise been made. Such Stock Units will be credited to the Participant's Stock Unit Account as soon as administratively practicable after the determination of the number of Stock Units has been made pursuant to the preceding sentence.

Bonus Deferrals made in Stock and RSU Deferrals will be credited to the Stock Unit Account as provided in Section 4.2(b).

In the sole and absolute discretion of the Plan Administrator, more than one Stock Unit Account may be established for each Participant to facilitate record keeping convenience and accuracy.

(i) The Stock Units credited to a Participant's Stock Unit Account will be used solely as a device for determining the number of shares of Stock eventually to be distributed to the Participant in accordance with this Plan. The Stock Units will not be treated as property of the Participant or as a trust fund of any kind. No Participant will be entitled to any voting or other stockholder rights with respect to Stock Units credited under this Plan.

(ii) If the outstanding shares of Stock are increased, decreased, or exchanged for a different number or kind of shares or other securities, or if additional shares or new or different shares or other securities are distributed with respect to such shares of Stock or other securities, through merger, consolidation, spin-off, sale of all or substantially all the assets of the Company, reorganization, recapitalization, reclassification, stock dividend, stock split, reverse stock split or other distribution with respect to such shares of Stock or other securities, an appropriate and proportionate adjustment in

a manner consistent with section 409A of the Code will be made by the Human Resources Committee in the number and kind of Stock Units credited to a Participant's Stock Unit Account.

(c) **Accounts Held in Trust** . Amounts credited to Participants' Accounts may be secured by one or more trusts, as provided in Section 7.1, but will be subject to the claims of the general creditors of each such Participant's Employer. Although the principal of such trust and any earnings or losses thereon will be separate and apart from other funds of the Employer and will be used for the purposes set forth therein, neither the Participants nor their Beneficiaries will have any preferred claim on, or any beneficial ownership in, any assets of the trust before the time such assets are paid to the Participant or Beneficiaries as benefits and all rights created under this Plan will be unsecured contractual rights of Plan Participants and Beneficiaries against the Employer. Any assets held in the trust with respect to a Participant will be subject to the claims of the general creditors of that Participant's Employer under federal and state law in the event of insolvency. The assets of any trust established pursuant to this Plan will never inure to the benefit of the Employer and the same will be held for the exclusive purpose of providing benefits to that Employer's Participants and their beneficiaries.

4.6 Investment Crediting Rates. At the time the Participant makes an Election under Section 4.1, he must specify the type of investment crediting rate option with which he would like the Company, in its sole and absolute discretion, to credit his Account as described in this Section 4.6. Such investment crediting rate Election will apply to all deferrals and contributions under the Plan, except for Bonus Deferrals made in Stock and RSU Deferrals which will automatically be credited to the Stock Unit Account as provided in Section 4.2(b) and Section 4.3.

(a) **Cash Investment Crediting Rate Options** . A Participant may make an Election as to the type of investment in which the Participant would like Compensation and Bonus Deferrals to be deemed invested for purposes of determining the amount of earnings to be credited or losses to be debited to his Cash Account. The Participant will specify his preference from among the following possible investment crediting rate options:

(i) An annual rate of interest equal to one hundred and twenty percent (120%) of the long-term applicable federal rate, compounded daily; or

(ii) One or more benchmark mutual funds.

A Participant may make elect, on a daily basis, to modify the investment crediting rate preference under this Section 4.6(a) by making a new Election with respect to such investment crediting rate. Notwithstanding any request made by a Participant, the Company, in its sole and absolute discretion, will determine the investment rate with which to credit amounts deferred by Participants under this Plan, provided, however, that if the Company chooses an investment crediting rate other than the investment crediting rate requested by the Participant, such investment crediting rate cannot be less than (i) above.

(b) **Stock Units** . A Participant may make an Election to have all or a portion of his Compensation and Bonus Deferrals to be deemed invested in Stock Units. Any request to have Compensation and Bonus Deferrals to be deemed invested in Stock Units is irrevocable with respect to such Compensation and Bonus Deferrals and such amounts will be distributed in an equivalent whole number of shares of Stock pursuant to the provisions of Article V. Any fractional share interests will be paid in cash with the last distribution.

(c) **Deemed Election** . In his request(s) pursuant to this Section 4.6, the Participant may request that all or any portion of his Account (in whole percentage increments) be deemed invested in one or more of the investment crediting rate preferences provided under the Plan as communicated from time to time by the RPAC. Although a Participant may express an investment crediting rate preference, the Company will not be bound by such request. If a Participant fails to set forth his investment crediting rate preference under this Section 4.6, he will be deemed to have elected an annual rate of interest equal to the rate of interest set forth in Section 4.6(a)(i) (*i.e.* , one hundred and twenty percent (120%) of the long-term applicable federal rate, compounded daily). The RPAC will select from time to time, in its sole and absolute discretion, the possible investment crediting rate options to be offered under the Plan.

(d) **Employer Contributions** . Matching Contributions to the Plan made by the Employer and allocated to a Participant's Account pursuant to Section 4.3 will be credited with the same investment crediting rate as the Participant's associated Base with Match Deferrals and/or Bonus with Match Deferrals for the relevant Plan Year. Discretionary Contributions, if any, made by the Employer and allocated to a Participant's Account pursuant to Section 4.4 will be credited with the investment crediting rate specified (or deemed specified) by such Participant in his Election for the relevant Plan Year with respect to the Participant's Base Deferrals and Bonus Deferrals.

A Participant will retain the right to change the investment crediting rate applicable to Matching Contributions and Discretionary Contributions as provided in this Section 4.6.

(e) **Prior Plan Contributions** . The Company transferred Participant 2005 employee deferrals and employer contributions under the 2001 DCP to this Plan and permitted Participants to express an investment crediting rate preference with respect to such transferred amounts. Such transferred amounts will be administered pursuant to the terms of this Plan.

End of Article IV

ARTICLE V
DISTRIBUTION OF BENEFITS

5.1 Distribution Election. During each Open Enrollment Period, the Eligible Person must make an Election as to the time and manner in which his Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, RSU Deferrals and/or Discretionary Deferrals and any associated Matching Contributions or Discretionary Contributions will be paid. A Participant may make a separate distribution Election for each type of Participant Deferral or Employer Contribution for each Plan Year beginning on or after January 1, 2010 in which he elects to make Participant Deferrals to the Plan. The Participant may not modify his Election as to the manner in which such Participant Deferrals or Employer Contributions will be paid.

For Plan Years beginning before January 1, 2010, the Participant had to specify upon his initial enrollment in the Plan the time and form in which distributions of Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, RSU Deferrals and/or Discretionary Deferrals and any associated Matching Contributions or Discretionary Contributions would be made upon a Termination of Employment and such termination distribution election governed all deferrals or Employer Contributions made to the Plan before January 1, 2010 (*i.e.* , deferrals and Employer Contributions made during the 2005, 2006, 2007, 2008 and 2009 Plan Years). Alternatively, the Participant could have elected to receive a Scheduled In-Service Withdrawal of his Base Deferrals, Bonus Deferrals, RSU Deferrals and/or Discretionary Deferrals (if allowed by the RPAC).

(a) **Time of Distribution.** A Participant who elects to receive a Scheduled In-Service Withdrawal with respect to Base Deferrals, Bonus Deferrals, RSU Deferrals or Discretionary Deferrals will receive the deferred amount, as adjusted for earnings and losses, in a lump sum at the time specified in his Election. In the event that the Participant incurs a Termination of Employment before his Scheduled In-Service Withdrawal date, his Scheduled In-Service Withdrawal election will be cancelled and of no effect and such amounts will be paid according to the Participant's Termination of Employment distribution Election with respect to the Plan Year for which the Scheduled In-Service Withdrawal amounts relate (*i.e.* , the Plan Year such amounts were deferred) or if no Termination of Employment distribution Election is on file, in a lump sum upon such Termination of Employment based on the Plan's default form of payment.

A Participant who elects to receive his Base Deferrals, Bonus Deferrals, Base with Match Deferrals, Bonus with Match Deferrals, RSU Deferrals and/or Discretionary Deferrals and any associated Matching Contributions or Discretionary Contributions made for a Plan Year upon his Termination of Employment, may receive such amounts at any of the following times:

(i) Subject to the six (6) month delay applicable to Key Employees described in Section 5.2, as soon as practicable after the Participant's Termination of Employment;

(ii) In the twelfth (12th) month following the Participant's Termination of Employment; or

(iii) In the twenty-fourth (24th) month following the Participant's Termination of Employment.

Such amounts may be paid in the form of a lump sum or in the form of annual installments over a period of one (1) to fifteen (15) years. Such lump sum or installments will be made in cash or in Stock, or in a combination thereof, depending on the Participant's investment crediting rates as provided in Section 4.6. If the Participant's Account is paid in installments, such Account will be revalued during the term of such installments based on procedures established by the Plan Administrator.

A Participant who dies while an Employee or a Director, as applicable, will be deemed to have incurred a Termination of Employment on the date of his death; provided, however, that amounts payable pursuant to the Plan on account of death will not be subject to the six (6) month delay applicable to Key Employees.

(b) **Failure to Elect Distribution.** In the event that a Participant fails to elect the manner in which his Account balance will be paid upon his Termination of Employment, such Account balance will be paid in the form of a lump sum as soon as practicable following the Participant's Termination of Employment, subject to the six (6) month delay applicable to Key Employees described in Section 5.2.

(c) **Taxation of Distributions.** All distributions from the Plan will be taxable as ordinary income when received and subject to appropriate withholding of income taxes. In the case of distributions in Stock, the appropriate number of shares of Stock may be sold to satisfy such withholding obligations pursuant to administrative procedures adopted by the Plan Administrator.

5.2 Termination Distributions to Key Employees. Distributions under this Plan that are payable to a Key Employee on account of a Termination of Employment will be delayed for a period of six (6) months following such Participant's Termination of Employment. This six (6) month restriction will not apply, or will cease to apply, with respect to a distribution to a Participant's Beneficiary by reason of the death of the Participant.

5.3 Scheduled In-Service Withdrawals. A Participant who elects a Scheduled In-Service Withdrawal pursuant to Section 4.2 (regarding Compensation and Bonus Deferrals), Section 4.3 (regarding RSU Deferrals) may subsequently elect to delay such distribution for a period of at least five (5) additional calendar years; provided, that such Election is made at least (12) twelve months before the date that such distribution would otherwise be made. Further, in the event that a Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment before the Scheduled Withdrawal Date, the Participant's Scheduled In-Service Withdrawal Election and Compensation and Bonus Deferral and/or RSU Deferral Election under Section 4.2 or Section 4.3 will be cancelled and the Participant's entire Account balance will be paid according to the Participant's termination distribution Election as provided in Section 5.1.

5.4 Unforeseeable Emergency. Upon application by the Participant, the Plan Administrator, in its sole and absolute discretion, may direct payment of all or a portion of the Participant's Account balance before his Termination of Employment and any Scheduled Withdrawal

Date in the event of an Unforeseeable Emergency. Any such application will set forth the circumstances constituting such Unforeseeable Emergency. The Plan Administrator will determine whether to grant an application for a distribution on account of an Unforeseeable Emergency in accordance with guidance issued pursuant to section 409A of the Code.

A Participant who takes an Unforeseeable Emergency distribution pursuant to this Section 5.4 (including amounts attributable to 2005 employee deferrals and employer contributions made under the 2001 DCP which are transferred to and administered under this Plan) will have his Participant Deferrals under this Plan suspended for the remainder of the Plan Year in which such Unforeseeable Emergency distribution occurs. In addition, such Participant will be ineligible to participate in the Plan for purposes of making Participant Deferrals and receiving an Employer Contribution for the Plan Year following the year in which such distribution occurs.

5.5 Death of a Participant. If a Participant dies while employed by the Employer, the Participant's Account balance will be paid to the Participant's Beneficiary in the manner elected (or deemed elected) by the Participant pursuant to Section 5.1; provided, that the six (6) month restriction on distributions to Key Employees under Section 5.2 will not apply.

In the event a terminated Participant dies while receiving installment payments, the remaining installments will be paid to the Participant's Beneficiary as such payments become due in accordance with Section 5.1.

In the event a terminated Participant dies before receiving his lump sum payment or before he begins receiving installment payments, the lump sum payment or installment payments will be paid to the Participant's Beneficiary as such payments become due in accordance with Section 5.1; provided, that the six (6) month restriction on distributions to Key Employees under Section 5.2 will not apply.

5.6 Withholding. Any taxes or other legally required withholdings from Compensation and Bonus Deferrals, RSU Deferrals, termination distributions, Scheduled In-Service Withdrawal payments and Unforeseeable Emergency distributions to Participants or Beneficiaries under the Plan will be deducted and withheld by the Employer, benefit provider or funding agent as required pursuant to applicable law. To the extent amounts are payable under this Plan in Stock, the appropriate number of shares of Stock may be withheld to satisfy such withholding obligation. A Participant or Beneficiary will be permitted to make a withholding election with respect to any federal and state tax withholding applicable to such distribution.

5.7 Impact of Reemployment on Benefits. If a Participant incurs a Termination of Employment and begins receiving installment payments from the Plan and such Participant is reemployed by the Employer, then such Participant's installment payments will continue as scheduled during the period of his reemployment.

End of Article V

ARTICLE VI
PAYMENT LIMITATIONS

6.1 Spousal Claims.

(a) In the event that an Alternate Payee is entitled to all or a portion of a Participant's Accounts pursuant to the terms of a DRO, such Alternate Payee will have the following distribution rights with respect to such Participant's Account to the extent set forth pursuant to the terms of the DRO:

(i) payment of benefits in a lump sum, in cash or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.6 and the terms of the DRO, as soon as practicable following the acceptance of the DRO by the Plan Administrator;

(ii) payment of benefits in a lump sum in cash or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.6 and the terms of the DRO, twelve (12) months following, or twenty four (24) months following, the acceptance of the DRO by the Plan Administrator;

(iii) payment of benefits in substantially equal annual installments, in cash and/or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.6 and the terms of the DRO, over a period of not less than one (1) nor more than fifteen (15) years from the date the DRO is accepted by the Plan Administrator; and

(iv) payment of benefits in substantially equal annual installments, in cash and/or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.6 and the terms of the DRO, over a period of not less than one (1) nor more than fifteen (15) years beginning twelve (12) months following, or twenty four (24) months following, the date the DRO is accepted by the Plan Administrator.

An Alternate Payee with respect to a DRO that provides for any of the distributions described in subsections (ii), (iii), or (iv) above, must complete and deliver to the Plan Administrator all required forms within thirty (30) days from the date the Alternate Payee is notified by the Plan Administrator that the DRO has been accepted. Any Alternate Payee who does not complete and deliver to the Plan Administrator all required forms and/or whose DRO does not provide for any of the distributions described in subsections (ii), (iii), or (iv) above will receive his benefits in a lump sum according to subsection (i) above. Unvested RSUs may not be transferred pursuant to a DRO.

(b) Any taxes or other legally required withholdings from payments to such Alternate Payee will be deducted and withheld by the Employer, benefit provider or funding agent. To the extent amounts are payable under this Plan in Stock, the appropriate number of shares of Stock may be sold to satisfy such withholding obligation. The Alternate Payee will be permitted to make a withholding election with respect to any federal and state tax withholding applicable to such payments.

(c) The Plan Administrator will have sole and absolute discretion to determine whether a judgment, decree or order is a DRO, to determine whether a DRO will be accepted for purposes of this Section 6.1 and to make interpretations under this Section 6.1, including determining who is to receive benefits, all calculations of benefits and determinations of the form of such benefits, and the amount of taxes to be withheld. The decisions of the Plan Administrator will be binding on all parties with an interest.

(d) Any benefits payable to an Alternate Payee pursuant to the terms of a DRO will be subject to all provisions and restrictions of the Plan and any dispute regarding such benefits will be resolved pursuant to the Plan claims procedure in Article VIII.

6.2 Legal Disability. If a person entitled to any payment under this Plan is, in the sole judgment of the Plan Administrator, under a legal disability, or otherwise is unable to apply such payment to his own interest and advantage, the Plan Administrator, in the exercise of its discretion, may direct the Employer or payer of the benefit to make any such payment in any one or more of the following ways:

(a) Directly to such person;

(b) To his legal guardian or conservator; or

(c) To his spouse or to any person charged with the duty of his support, to be expended for his benefit and/or that of his dependents.

The decision of the Plan Administrator will in each case be final and binding upon all persons in interest, unless the Plan Administrator reverses its decision due to changed circumstances.

6.3 Assignment. Except as provided in Section 6.1, no Participant or Beneficiary will have any right to assign, pledge, transfer, convey, hypothecate, anticipate or in any way create a lien on any amounts payable under this Plan. No amounts payable under this Plan will be subject to assignment or transfer or otherwise be alienable, either by voluntary or involuntary act, or by operation of law, or subject to attachment, execution, garnishment, sequestration or other seizure under any legal, equitable or other process, or be liable in any way for the debts or defaults of Participants and their Beneficiaries.

End of Article VI

ARTICLE VII
FUNDING

7.1 Funding.

(a) **Funding** . Benefits under this Plan will be funded solely by the Employer. Benefits under this Plan will constitute an unfunded general obligation of the Employer, but the Employer may create reserves, funds and/or provide for amounts to be held in trust to fund such benefits on its behalf. Payment of benefits may be made by the Employer, any trust established by the Employer or through a service or benefit provider to the Employer or such trust.

(b) **Rabbi Trust** . Upon a Change of Control, the following will occur:

(i) the Trust will become (or continue to be) irrevocable;

(ii) for three (3) years following a Change of Control, the Trustee can only be removed as set forth in the Trust;

(iii) if the Trustee is removed or resigns within three (3) years of a Change of Control, the Trustee will select a successor Trustee, as set forth in the Trust;

(iv) for three (3) years following a Change of Control, the Company will be responsible for directly paying all Trustee fees and expenses, together with all fees and expenses incurred under Article VIII relating to the RPAC, Plan Administrator, and Plan administrative expenses; and

(v) the Trust Agreement may be amended only as set forth in the Trust (with the Trustee's consent); provided, however, that no such amendment will (A) change the irrevocable nature of the Trust; (B) adversely affect a Participant's rights to benefits without the consent of the Participant; (C) impair the rights of the Company's creditors under the Trust; or (0) cause the Trust to fail to be a "grantor trust" pursuant to Code sections 671 -- 679.

7.2 Creditor Status. Participants and their Beneficiaries will be general unsecured creditors of their respective Employer with respect to the payment of any benefit under this Plan, unless such benefits are provided under a contract of insurance or an annuity contract that has been delivered to Participants, in which case Participants and their Beneficiaries will look to the insurance carrier or annuity provider for payment, and not to the Employer. The Employer's obligation for such benefit will be discharged by the purchase and delivery of such annuity or insurance contract.

End of Article VII

ARTICLE VIII
ADMINISTRATION

8.1 The RPAC. The overall administration of the Plan will be the responsibility of the RPAC.

8.2 Powers of RPAC. The RPAC will have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. In order to effectuate the purposes of the Plan, the RPAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the Plan;

(c) To construe the Plan and to make equitable adjustments for any mistakes or errors made in the administration of the Plan; and

(d) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the Plan and the trust established to secure the assets of the Plan (i) when differences of opinion arise between the Company, an Affiliate, the Plan Administrator, the Trustee, a Participant, or any of them, and (ii)whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the Plan for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the RPAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the Plan.

8.3 Appointment of Plan Administrator. The RPAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the Plan on a daily basis. The RPAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the RPAC.

8.4 Duties of Plan Administrator. The Plan Administrator will have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. The Plan Administrator will have the following powers and duties:

(a) To direct the administration of the Plan in accordance with the provisions herein set forth;

(b) To adopt rules of procedure and regulations necessary for the administration of the Plan, provided such rules are not inconsistent with the terms of the Plan;

(c) To determine all questions with regard to rights of Employees, Directors, Participants, and Beneficiaries under the Plan including, but not limited to, questions involving eligibility of an Employee or Director to participate in the Plan and the value of a Participant's Accounts;

(d) To enforce the terms of the Plan and any rules and regulations adopted by the RPAC;

(e) To review and render decisions respecting a claim for a benefit under the Plan;

(f) To furnish the Employer with information that the Employer may require for tax or other purposes;

(g) To engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) To prescribe procedures to be followed by Participants in obtaining benefits;

(i) To receive from the Employer and from Participants such information as is necessary for the proper administration of the Plan;

(j) To establish and maintain, or cause to be maintained, the individual Accounts described in Section 4.4;

(k) To create and maintain such records and forms as are required for the efficient administration of the Plan;

(l) To make all determinations and computations concerning the benefits, credits and debits to which any Participant, or other Beneficiary, is entitled under the Plan;

(m) To give the Trustee of the trust established to serve as a source of funds under the Plan specific directions in writing with respect to:

(i) making distribution payments, giving the names of the payees, specifying the amounts to be paid and the time or times when payments will be made; and

(ii) making any other payments which the Trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator;

(n) To comply with all applicable lawful reporting and disclosure requirements of the Act;

(o) To comply (or transfer responsibility for compliance to the Trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(p) To construe the Plan, in its sole and absolute discretion, and make equitable adjustments for any errors made in the administration of the Plan.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the Plan.

8.5 Indemnification of RPAC and Plan Administrator. To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations, the Employer agrees to hold harmless and indemnify the RPAC and Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising out of any act or omission relating to or in connection with the Plan other than losses resulting from the RPAC's, or any such person's commission of fraud or willful misconduct.

8.6 Claims for Benefits.

(a) **Initial Claim** . In the event that an Employee, Director, Eligible Person, Participant or his Beneficiary claims to be eligible for benefits, or claims any rights under this Plan, such claimant must complete and submit such claim forms and supporting documentation as will be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any Participant or Beneficiary who feels unfairly treated as a result of the administration of the Plan, must file a written claim, setting forth the basis of the claim, with the Plan Administrator. In connect ion with the determination of a claim, or in connection with review of a denied claim, the claimant may examine this Plan, and any other pertinent documents generally available to Participants that are specifically related to the claim.

A written notice of the disposition of any such claim will be furnished to the claimant within ninety (90) days after the claim is filed with the Plan Administrator. Such notice will refer, if appropriate, to pertinent provisions of this Plan, will set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of this Plan) and, where appropriate, will describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the claimant will also be notified of the Plan's claim review procedure and the time limits applicable to such procedure, including the claimant's right to arbitration following an adverse benefit determination on review as provided below. All benefits provided in this Plan as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review** . Within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant may file with the RPAC a written request for review of his claim. In connection with the request for review, the claimant will be entitled to be represented by counsel and will be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the claimant does not file a written request for review within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant will be deemed to have accepted the Plan Administrator's written disposition, unless the claimant was physically or mentally incapacitated so as to be unable to request review within the ninety (90) day period.

(c) **Decision on Review** . After receipt by the RPAC of a written application for review of his claim, the RPAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The RPAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on review of the claim will be made by the RPAC at its next meeting following receipt of the written request for review. If no meeting of the RPAC is scheduled within forty-five (45) days of receipt of the written request for review, then the RPAC will hold a special meeting to review such written request for review within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be rendered within ninety (90) days of receipt of the request for review. In any event, if a claim is not determined by the RPAC within ninety (90) days of receipt of written submission for review, it will be deemed to be denied.

The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the benefit determination is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant Plan provisions on which the decision was based. Such decision will also advise the claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the RPAC will be final and conclusive.

(d) **Arbitration** . In the event the claims review procedure described in this Section 8.6 does not result in an outcome thought by the claimant to be in accordance with the Plan document, he may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within sixty (60) days after receiving the RPAC's denial or deemed denial of his request for review and before bringing suit in court. The arbitration will be conducted pursuant to the American Arbitration Association (" **AAA** ") Rules on Employee Benefit Claims.

The arbitrator will be mutually selected by the Participant and the RPAC from a list of arbitrators who are experienced in nonqualified deferred compensation plan benefit matters that is provided by the AAA. If the parties are unable to agree on the selection of an arbitrator within ten (10) days of receiving the list from the AAA, the AAA will appoint an arbitrator. The arbitrator's review will be limited to interpretation of the Plan document in the context of the particular facts involved. The claimant, the RPAC and the Employer agree to accept the award of the arbitrator as binding, and all exercises of power by the arbitrator hereunder will be final, conclusive and binding on all interested parties, unless found by a court of competent jurisdiction, in a final judgment that is no longer subject to review or appeal, to be arbitrary and capricious. The claimant, RPAC and the Company agree that the venue for the arbitration will be in Dallas, Texas. The costs of arbitration will be paid by the Employer; the costs of legal representation for the claimant or witness costs for the claimant will be borne by the claimant; provided, that, as part of his award,

the Arbitrator may require the Employer to reimburse the claimant for all or a portion of such amounts.

The following discovery may be conducted by the parties: interrogatories, demands to produce documents, requests for admissions and oral depositions. The arbitrator will resolve any discovery disputes by such pre hearing conferences as may be needed. The Company, RPAC and claimant agree that the arbitrator will have the power of subpoena process as provided by law. Disagreements concerning the scope of depositions or document production, its reasonableness and enforcement of discovery requests will be subject to agreement by the Company and the claimant or will be resolved by the arbitrator. All discovery requests will be subject to the proprietary rights and rights of privilege and other protections granted by applicable law to the Company and the claimant and the arbitrator will adopt procedures to protect such rights. With respect to any dispute, the Company, RPAC and the claimant agree that all discovery activities will be expressly limited to matters 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 this Plan. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the Plan.

8.7 Receipt and Release of Necessary Information. In implementing the terms of this Plan, the RPAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the RPAC or Plan Administrator deems to be necessary for such purposes. Any Participant or Beneficiary claiming benefits under this Plan will furnish to the RPAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

8.8 Overpayment and Underpayment of Benefits. The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Participant or Beneficiary receives an underpayment of benefits, the Plan Administrator will direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Participant or Beneficiary, for whatever reason, the Plan Administrator may, in its sole and absolute discretion, (a) withhold payment of any further benefits under the Plan until the overpayment has been collected; provided, that the entire amount of reduction in any calendar year does not exceed five thousand dollars ($5,000), and the reduction is made at the same time and in the same amount as the debt otherwise would have been due and collected from the Participant, or (b) may require repayment of benefits paid under this Plan without regard to further benefits to which the Participant or Beneficiary may be entitled.

8.9 **Change of Control.** Upon a Change of Control and for the following three (3) years thereafter, if any arbitration arises relating to an event occurring or a claim made with in three (3) years of a Change of Control, (i) the arbitrator will not decide the claim based on an abuse of discretion principle or give the previous RPAC decision any special deference, but rather will determine the claim de novo based on its own independent reading of the Plan; and (ii) the Company will pay the Participant's reasonable legal and other related fees and expenses upon the Participant's provision of satisfactory documentation of such expenses with such reimbursement being made no later than the close of the second taxable year following the year in which such expenses were incurred.

End of Article VIII

ARTICLE IX
OTHER BENEFIT PLANS OF THE COMPANY

9.1 **Other Plans.** Nothing contained in this Plan will prevent a Participant before his death, or a Participant's spouse or other Beneficiary after such Participant's death, from receiving, in addition to any payments provided for under this Plan, any payments provided for under any other plan or benefit program of the Employer, or which would otherwise be payable or distributable to him, his surviving spouse or Beneficiary under any plan or policy of the Employer or otherwise. Nothing in this Plan will be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees and/or Directors. Unless otherwise specifically provided in any plan of the Company intended to "qualify" under section 401 of the Code, Compensation and Bonus Deferrals made under this Plan will constitute earnings or compensation for purposes of determining contributions or benefits under such qualified plan.

End of Article IX

ARTICLE X
AMENDMENT AND TERMINATION OF THE PLAN

10.1 Continuation. The Company intends to continue this Plan indefinitely, but nevertheless assumes no contractual obligation beyond the promise to pay the benefits described in this Plan.

10.2 Amendment of Plan. The Company, through an action of the Human Resources Committee, reserves the right in its sole and absolute discretion to amend this Plan in any respect at any time, except that upon or during the two (2) year period after any Change of Control of the Company, (a) Plan benefits cannot be reduced, (b) Articles VIII and X and Plan Section 7.1(b) cannot be changed, and (c) (except as provided in Section 10.3) no prospective amendment that adversely affects the rights or obligations of a Participant may be made unless the affected Participant receives at least one (1) year's advance written notice of such amendment.

Moreover, no amendment may ever be made that retroactively reduces or diminishes the rights of any Participant to the benefits described herein that have been accrued or earned through the date of such amendment, even if a Termination of Employment has not yet occurred with respect to such Participant.

In addition to the Human Resources Committee, 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 Human Resources Committee in order to determine whether such change would constitute a material amendment to the Plan.

The provisions of this Section 10.2 will not restrict the right of the Company to terminate this Plan under Section 10.3 below or the termination of an Affiliate's participation under Section 10.4 below.

10.3 Termination of Plan. The Company, through an action of the Human Resources Committee, may terminate or suspend this Plan in whole or in part at any time, provided that no such termination or suspension will deprive a Participant, or person claiming benefits under this Plan through a Participant, of any amount credited to his Accounts under this Plan up to the date of suspension or termination, except as required by applicable law and pursuant to the valuation of such Accounts pursuant to Section 4.6.

The Human Resources Committee may decide to liquidate the Plan upon termination under the following circumstances:

(a) **Corporate Dissolution or Bankruptcy** . The Human Resources Committee may terminate and liquidate the Plan within twelve (12) months of a corporate dissolution taxed under section 331 of the Code or with the approval of a bankruptcy court pursuant to 11 U.S.C. § 503(b)(1)(A), provided that the amounts deferred under the Plan are included in Participants' gross income in the latest of the following years (or if earlier, the taxable year in which the amount is actually or constructively received):

(i) The calendar year in which the Plan termination and liquidation occurs.

(ii) The first calendar year in which the amount is no longer subject to a substantial risk of forfeiture.

(iii) The first calendar year in which the payment is administratively practicable.

(b) **Change in Control** . The Human Resources Committee may terminate and liquidate the Plan within the thirty (30) days preceding or the twelve (12) months following a "change in control" as defined in Treasury Regulation 1.409A-3(i)(5) provided that all plans or arrangements that would be aggregated with the Plan under section 409A of the Code are also terminated and liquidated with respect to each Participant that experienced the change in control event so that under the terms of the Plan and all such arrangements the Participant is required to receive all amounts of compensation deferred under such arrangements within twelve (12) months of the termination of the Plan or arrangement, as applicable. In the case of a Change of Control event which constitutes a sale of assets, the termination of the Plan pursuant to this Section 10.3(b) may be made with respect to the Employer that is primarily liable immediately after the change of control transaction for the payment of benefits under the Plan.

(c) **Termination of Plan** . The Human Resources Committee may terminate and liquidate the Plan provided that (i) the termination and liquidation does not occur by reason of a downturn of the financial health of the Company or an Employer, (ii) all plans all plans or arrangements that would be aggregated with the Plan under section 409A of the Code are also terminated and liquidated, (iii) no payments in liquidation of the Plan are made within twelve (12) months of the date of termination of the Plan other than payments that would be made in the ordinary course operation of the Plan, (iv) all payments are made within twenty four (24) months of the date the Plan is terminated and (v) the Company or the Employer, as applicable depending on whether the Plan is terminated with respect to such entity, do not adopt a new plan that would be aggregated with the Plan within three (3) years of the date of the termination of the Plan.

10.4 Termination of Affiliate's Participation. An Affiliate may terminate its participation in the Plan at any time by an action of its governing body and providing written notice to the Company. Likewise, the Company may terminate an Affiliate's participation in the Plan at any time by an action of the Human Resources Committee and providing written notice to the Affiliate. The effective date of any such termination will be the later of the date specified in the notice of the termination of participation or the date on which the RPAC can administratively implement such termination. In the event that an Affiliate's participation in the Plan is terminated, each Participant employed by such Affiliate will continue to make Compensation and Bonus Deferrals, RSU Deferrals or Discretionary Deferrals, as applicable, in effect at the time of such termination for the remainder of the Plan Year in which the termination occurs. Thereafter, each Participant employed by such Affiliate will continue to participate in the Plan as an inactive Participant and will be entitled to a distribution of his entire Account or a portion thereof upon the earlier of his Scheduled Withdrawal Date, if any, or his Termination of Employment, in the form elected (or deemed elected) by such Participant pursuant to Section 5.1.

End of Article X

ARTICLE XI
MISCELLANEOUS

11.1 No Reduction of Employer Rights. Nothing contained in this Plan will be construed as a contract of employment between the Employer and an Employee, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause or as a right of any Director to be renominated to serve as a Director.

11.2 Provisions Binding. All of the provisions of this Plan will be binding upon all persons who will be entitled to any benefit hereunder, their heirs and personal representatives.

End of Article IX

IN WITNESS WHEREOF , this Fifth Amended and Restated Tenet 2006 Deferred Compensation Plan has been executed on this 30 th of November , 2018, effective as of January 1, 2019, except as specifically provided otherwise here

TENET HEALTHCARE CORPORATION

By: /s/ Paul Slavin

Paul Slavin, Vice President,
Executive and Corp. HR Services

EXHIBIT A [1]
LIMITS ON ELIGIBILITY AND PARTICIPATION

Section 3.1 of the Tenet 2006 Deferred Compensation Plan (the " **Plan** ") provides the Retirement Plans Administration Committee (" **RPAC** ") and Plan Administrator with the authority to limit the classification of Employees eligible to participate in the Plan, limit the time of an Employee's enrollment in the Plan to an Open Enrollment Period and/or modify or terminate an Eligible Person's participation in the Plan and states that any such limitation will be set forth in this Exhibit A. Capitalized terms used in this Exhibit that are not defined herein will have the meaning set forth in Section 2.1.

- The classification of Employees eligible to participate in the Plan will be limited to those employees who are paid from a Tenet payroll (i.e., eligible employees who were previously employed by Vanguard Health System will not be eligible to participate in the Plan until they transition to a Tenet payroll).

[1] This Exhibit A may be updated from time to time without the need for a formal amendment to the Plan.

FIFTH AMENDMENT TO STOCK PLEDGE AGREEMENT

This Fifth Amendment to Stock Pledge Agreement (this " Amendment ") is entered into as of December 1, 2016, among Tenet Healthcare Corporation, a Nevada corporation (the " Company "), each of the other entities listed on the signature pages hereof as Pledgors, and The Bank of New York Mellon Trust Company, N.A., as collateral trustee for the Secured Parties (in such capacity, the " Collateral Trustee ").

RECITALS

WHEREAS, reference is made to that certain Stock Pledge Agreement, dated as of March 3, 2009, by the Company and the other Pledgors in favor of the Collateral Trustee, as amended by that certain First Amendment to Stock Pledge Agreement, dated as of May 8, 2009, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Second Amendment to Stock Pledge Agreement, dated as of June 15, 2009, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement, dated as of May 15, 2013 and executed by the pledgors party thereto, as amended by that certain Pledge Amendment to the Stock Pledge Agreement, dated as of May 15, 2013, between the Company and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement, dated as of October 1, 2013 and executed by the pledgors party thereto, as amended by that certain Pledge Amendment to the Stock Pledge Agreement, dated as of October 1, 2013, by the Company and the Collateral Trustee, as amended by that certain Third Amendment to Stock Pledge Agreement, dated as of March 7, 2014, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Fourth Amendment to Stock Pledge Agreement, dated as of March 23, 2015, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement, dated as of March 23, 2015 and executed by the pledgors party thereto, as amended by that certain Pledge Amendment to the Stock Pledge Agreement, dated as of March 23, 2015, by the Company and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement, dated as of October 2, 2015 and executed by the pledgors party thereto, and as amended by that certain Pledge Amendment to the Stock Pledge Agreement, dated as of October 5, 2015, between the Company and the Collateral Trustee (as so amended, the " Stock Pledge Agreement ");

WHEREAS, pursuant to that certain Indenture, dated as of November 6, 2001 (the " Base Indenture "), between the Company and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, as trustee (the " Trustee "), as supplemented by the Twenty-Eighth Supplemental Indenture thereto, dated as of December 1, 2016 (and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twenty-Eighth Supplemental Indenture "), the Company

has issued $750,000,000 principal amount of its senior secured second lien notes due 2022 (the " Second Lien 2022 Notes "; the Second Lien 2022 Notes, collectively with any other Securities (as such term is defined in the Base Indenture or the 2013 Base Indenture) of the Company issued and authenticated under the Junior Priority Indentures (as defined below) that are designated by the Company as, and are entitled the benefits of, being Junior Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof, the " Junior Lien Secured Notes ");

WHEREAS, the Secured Obligations in respect of which a security interest in the Collateral was created by the Stock Pledge Agreement include the obligations in respect of the:

(a) Fourteenth Supplemental Indenture to the Base Indenture, dated as of November 21, 2011, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 6.250% Senior Secured Notes due 2018 (the " 2018 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Fourteenth Supplemental Indenture ");

(b) Fifteenth Supplemental Indenture to the Base Indenture, dated as of October 16, 2012, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.750% Senior Secured Notes due 2020 (the " 4.75% 2020 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Fifteenth Supplemental Indenture ");

(c) Seventeenth Supplemental Indenture to the Base Indenture, dated as of February 5, 2013, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.500% Senior Secured Notes due 2021 (the " 4.5% 2021 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Seventeenth Supplemental Indenture ");

(d) Twentieth Supplemental Indenture to the Base Indenture, dated as of May 30, 2013, by and among the Company, the Trustee and the guarantors party thereto and relating to

the Company's 4.375% Senior Secured Notes due 2021 (the " 4.375% 2021 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twentieth Supplemental Indenture ");

(e) Twenty-Sixth Supplemental Indenture to the Base Indenture, dated as of June 16, 2015, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's Floating Rate Senior Secured Notes Due 2020 (the " Floating Rate 2020 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twenty-Sixth Supplemental Indenture ");

(f) Indenture dated as of September 27, 2013 (the " 2013 Base Indenture "), between THC Escrow Corporation and the Trustee (as supplemented by the First Supplemental Indenture thereto, dated as of October 1, 2013, among the Company, the Trustee and the guarantors party thereto, the Second Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Third Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " 2013 Indenture ")), pursuant to which the 6.00% Senior Secured Notes due 2020 were issued (the " 6.000% 2020 Notes "; the 6.000% 2020 Notes, collectively with the 4.375% 2021 Notes, the 4.5% 2021 Notes, the 4.75% 2020 Notes, the Floating Rate 2020 Notes, the 2018 Notes, and any other Securities (as such term is defined in the Base Indenture or the 2013 Base Indenture) of the Company issued and authenticated under the Indentures or the 2013 Indenture that are designated as, and are entitled to the benefits of, being First Priority Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof, are referred to herein as the " First Lien Secured Notes "; the First Lien Secured Notes, together with the Junior Lien Secured Notes, are referred to herein as the " Secured Notes ");

(g) the Guarantees in respect of the Secured Notes; and

(h) the obligations under that certain Letter of Credit Facility Agreement, dated as of March 7, 2014 (as amended or otherwise modified, the " LC Facility Agreement "), among the Company, certain financial institutions party thereto from time to time as letter of credit participants and issuers and Barclays Bank PLC, as administrative agent, and the guarantees in respect thereof;

WHEREAS, subject to the terms and conditions hereof, the parties hereto desire to and have agreed to amend the Stock Pledge Agreement to secure the obligations in respect of the Junior Lien Secured Notes, in each case to be designated as and entitled to the benefits of being Junior Stock Secured Debt (as defined in the Collateral Trust Agreement) under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

WHEREAS, the sole effect of this Amendment is to secure additional debt of the Company that is permitted by the terms of the Collateral Trust Agreement to be secured by the Collateral and to add references to such debt and the documents governing such debt, and that as such, pursuant to:

(a) Section 7.1 of the Stock Pledge Agreement;

(b) Section 7.1 of the Collateral Trust Agreement;

(c) Article VII of each of the Fourteenth Supplemental Indenture, Fifteenth Supplemental Indenture, Seventeenth Supplemental Indenture, Twentieth Supplemental Indenture and Twenty-Sixth Supplemental Indenture, and Section 902 of the 2013 Indenture; and

(d) Section 10.8 and 11.1 of the LC Facility Agreement, this Amendment may be entered into by the Company, the other pledgors party hereto and the Collateral Trustee without (i) the consent of the holders of the Notes or the holders of LC Obligations (as defined below) or (ii) direction to the Collateral Trustee by an Act of Required Stock Secured Debtholders (as defined in the Collateral Trust Agreement); and

WHEREAS, unless otherwise indicated, capitalized terms used herein without definition have the meanings ascribed to such terms in the Stock Pledge Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein contained, the Company and each other Pledgor signatory hereto hereby agrees with the Collateral Trustee as follows:

1. Section References . Unless otherwise expressly stated herein, all Section references herein shall refer to Sections of the Stock Pledge Agreement.

2. Amendments to Section 1.1 . Section 1.1 of the Stock Pledge Agreement is hereby amended by: (a) amending and restating the defined terms “2013 Indenture,” “Event of Default,” “First Lien Secured Obligations,” “First Lien Secured Parties,” “Junior Lien Secured Obligations,” “Junior Lien Secured Parties,” “Notes,” “Related Document,” “Secured Obligations,” “Secured Parties” and “Supplemental Indentures” in their entirety, and by adding the defined terms “Fifth Amendment,” “First Lien Secured Notes,” “First Priority Indentures,” “First Priority Supplemental Indentures,” “Holder,” “Junior Lien Secured Notes,” “Junior Priority Indentures,” “Junior Priority Supplemental Indentures” and “Note Guarantees,” in each case as set forth below, and (b) deleting the defined terms “Interim Loan Agreement,” “Interim Loan Agreement Guaranty Agreement,” “Interim Loan Agreement Obligations” and “Loan Guarantees” (all other

defined terms contained therein remain unchanged and to the extent that definitions contained in this Section 2 conflict with definitions contained in the Stock Pledge Agreement, the definitions contained in this Section 2 shall control):

" *2013 Indenture* " has the meaning specified in the Fifth Amendment.

" *Event of Default* " means an Event of Default, as such term is defined in any Indenture, any 2013 Indenture, the LC Facility Agreement or any other First-Priority Stock Lien Document or Junior Stock Lien Document (as such terms are defined in the Collateral Trust Agreement).

" *Fifth Amendment* " means the Fifth Amendment to Stock Pledge Agreement, dated as of December 1, 2016.

" *First Lien Secured Notes* " has the meaning specified in the Fifth Amendment.

" *First Lien Secured Obligations* " means (i) Obligations in respect of the First Lien Secured Notes and the related Note Guarantees and (ii) LC Obligations and obligations under the LC guarantees.

" *First Lien Secured Parties* " means (i) the Holders of First Lien Secured Notes, (ii) the LC Participants, LC Issuers and Administrative Agent under the LC Facility Agreement and any other holders of LC Obligations, (iii) the Trustee under each Indenture and each 2013 Indenture with respect to First Lien Secured Notes issued thereunder and (iv) the Collateral Trustee with respect to First Lien Secured Notes.

" *First Priority Indentures* " means, collectively, (i) the 2013 Indenture and (ii) the Base Indenture as severally supplemented by each First Priority Supplemental Indenture.

" *First Priority Supplemental Indentures* " means the Fourteenth Supplemental Indenture, the Fifteenth Supplemental Indenture, the Seventeenth Supplemental Indenture, the Nineteenth Supplemental Indenture, the Twentieth Supplemental Indenture, the Twenty-Second Supplemental Indenture, the Twenty-Fifth Supplemental Indenture, the Twenty-Sixth Supplemental Indenture, the Twenty-Seventh Supplemental Indenture and all other indentures supplemental to the Base Indenture in respect of which Securities are issued and authenticated that are designated as and entitled to the benefits of being First-Priority Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

" *Holder* " shall have the meaning given to such term in any Indenture or 2013 Indenture.

" *Indentures* " means, collectively, the First Priority Indentures and the Junior Priority Indentures.

" *Junior Lien Secured Notes* " has the meaning specified in the Fifth Amendment.

“ *Junior Lien Secured Obligations* ” means Obligations in respect of the Junior Lien Secured Notes and the related Note Guarantees.

“ *Junior Lien Secured Parties* ” means (i) the Holders of Junior Lien Secured Notes and (ii) the Collateral Trustee with respect to Junior Lien Secured Notes.

“ *Junior Priority Indentures* ” means, collectively, the Base Indenture as severally supplemented by each Junior Priority Supplemental Indenture.

“ *Junior Priority Supplemental Indentures* ” means the Twenty-Eighth Supplemental Indenture and all other indentures supplemental to the Base Indenture in respect of which Securities are issued and authenticated that are designated as, and entitled to the benefits of, being Junior Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

“ *Notes* ” means (i) the First Lien Secured Notes and (ii) the Junior Lien Secured Notes.

“ *Note Guarantees* ” means the Guarantees of the Company’s obligations under the Indentures, the 2013 Indenture and the Notes.

“ *Related Document* ” means the Indentures, the 2013 Indenture, the Notes, the Note Guarantees, the Collateral Trust Agreement, the LC Facility Agreement and Guarantee Agreement.

“ *Secured Obligations* ” means (i) the First Lien Secured Obligations and (ii) the Junior Lien Secured Obligations.

“ *Secured Parties* ” means (i) the First Lien Secured Parties and (ii) the Junior Lien Secured Parties.

“ *Supplemental Indentures* ” means, collectively, the First Priority Supplemental Indentures and the Junior Priority Supplemental Indentures.

3. Amendments to Section 7.1 . Section 7.1 of the Stock Pledge Agreement is hereby amended to delete the words “, Section 11.1 of the Interim Loan Agreement”.

4. Conditions Precedent . The effectiveness of this Amendment is subject to the Collateral Trustee’s receipt of each of the following:

(a) this Amendment, duly executed and delivered by the Company, each other Pledgor party hereto and the Collateral Trustee;

(b) an Officers’ Certificate (as defined in the Collateral Trust Agreement) to the effect that this Amendment will not result in a breach of any provision or covenant contained in any of the Secured Debt Documents (as defined in the Collateral Trust Agreement); and

(c) an opinion of counsel of the Company to the effect that the Collateral Trustee's execution of this Amendment is authorized and permitted by the Collateral Trust Agreement.

5. Reference to Stock Pledge Agreement . The Stock Pledge Agreement and the Related Documents, and any and all other agreements, documents or instruments now or hereafter executed and/or delivered pursuant to the terms hereof or pursuant to the terms of the Stock Pledge Agreement or the Related Documents, are hereby amended so that any reference therein to the Stock Pledge Agreement, whether direct or indirect, shall mean a reference to the Stock Pledge Agreement as amended hereby.

6. Counterparts . This Amendment may be executed by one or more of the parties to this Amendment on any number of separate counterparts (including by telecopy), each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Signature pages may be detached from multiple counterparts and attached to a single counterpart so that all signature pages are attached to the same document. Delivery of an executed counterpart by telecopy shall be effective as delivery of a manually executed counterpart.

7. Severability . Any provision of this Amendment that is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibitions or unenforceability without invalidating the remaining provisions hereof, and any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

8. Governing Law . THE INTERNAL LAW OF THE STATE OF NEW YORK SHALL GOVERN AND BE USED TO CONSTRUE THIS AMENDMENT WITHOUT GIVING EFFECT TO APPLICABLE PRINCIPLES OF CONFLICTS OF LAW TO THE EXTENT THAT THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION WOULD BE REQUIRED THEREBY.

9. Limited Effect . Except to the extent specifically amended or modified hereby, the provisions of the Stock Pledge Agreement shall not be amended, modified, impaired or otherwise affected hereby.

10. Responsibility of the Collateral Trustee . The Collateral Trustee is not responsible for the validity or sufficiency of this Amendment or the recitals contained herein. In no event shall the Collateral Trustee or Registrar (as defined in the Appointment of Registrar Letter dated March 23, 2015 between The Bank of New York Mellon Trust Company, N.A., as registrar (the " Registrar ") be charged with knowledge of the terms of, be subject to, or be required to comply with the Twenty-Eighth Supplemental Indenture. All such responsibilities of the Collateral Trustee shall be as set forth in the Collateral Trust Agreement.

[*Signature Pages Follow*]

IN WITNESS WHEREOF, each of the undersigned has caused this Amendment to be duly executed and delivered as of the date first above written.

TENET HEALTHCARE CORPORATION, *as a Pledgor*

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Vice President and Assistant Treasurer

AMERICAN MEDICAL (CENTRAL), INC.
AMI INFORMATION SYSTEMS GROUP, INC.
AMISUB (HEIGHTS), INC.
AMISUB (HILTON HEAD), INC.
AMISUB (TWELVE OAKS), INC.
AMISUB OF TEXAS, INC.
BROOKWOOD HEALTH SERVICES, INC.
CORAL GABLES HOSPITAL, INC.
CYPRESS FAIRBANKS MEDICAL CENTER, INC.
FMC MEDICAL, INC.
HEALTHCARE NETWORK CFMC, INC.
HEALTHCARE NETWORK HOLDINGS, INC.
HEALTHCARE NETWORK LOUISIANA, INC.
HEALTHCARE NETWORK MISSOURI, INC.
HEALTHCARE NETWORK TEXAS, INC.
HEALTHCORP NETWORK, INC.
HEALTH SERVICES NETWORK HOSPITALS, INC.
HEALTH SERVICES NETWORK TEXAS, INC.
LIFEMARK HOSPITALS, INC.
ORNDA HOSPITAL CORPORATION
SRRMC MANAGEMENT, INC.
TENET CALIFORNIA, INC.
TENET FLORIDA, INC.
TENET HEALTHSYSTEM MEDICAL, INC.
TENET HEALTHSYSTEM PHILADELPHIA, INC.
TENET PHYSICIAN SERVICES - HILTON HEAD, INC.
VANGUARD HEALTH FINANCIAL COMPANY, LLC
VANGUARD HEALTH HOLDING COMPANY I, LLC
VANGUARD HEALTH HOLDING COMPANY II, LLC
VANGUARD HEALTH MANAGEMENT, INC.
VANGUARD HEALTH SYSTEMS, INC.
VHS OF PHOENIX, INC.
VHS OF MICHIGAN, INC.
VHS VALLEY MANAGEMENT COMPANY, INC.,
each as a Pledgor

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Treasurer

BROOKWOOD BAPTIST HEALTH 1, LLC
VHS VALLEY HEALTH SYSTEM, LLC,
each as a Pledgor

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Assistant Treasurer

ACCEPTED AND AGREED
as of the date first above written:

THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A.,
as Collateral Trustee

By: /s/ Teresa Petta
Name: Teresa Petta
Title: Vice President

SIXTH AMENDMENT TO STOCK PLEDGE AGREEMENT

This Sixth Amendment to Stock Pledge Agreement (this " Amendment ") is entered into as of July 14, 2017, among Tenet Healthcare Corporation, a Nevada corporation (the " Company "), each of the other entities listed on the signature pages hereof as Pledgors, and The Bank of New York Mellon Trust Company, N.A., as collateral trustee for the Secured Parties (in such capacity, the " Collateral Trustee ").

RECITALS

WHEREAS, reference is made to that certain Stock Pledge Agreement, dated as of March 3, 2009, among the Company, the other Pledgors and the Collateral Trustee (as amended by that certain First Amendment to the Stock Pledge Agreement, dated as of May 8, 2009, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Second Amendment to the Stock Pledge Agreement, dated as of June 15, 2009, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Third Amendment to the Stock Pledge Agreement, dated as of March 7, 2014, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Fourth Amendment to the Stock Pledge Agreement, dated as of March 23, 2015, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Fifth Amendment to the Stock Pledge Agreement, dated as of December 1, 2016, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on May 15, 2013 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on May 15, 2013 by the Company and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on October 1, 2013 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on October 1, 2013 by the Company and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on March 23, 2015 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on March 23, 2015 by the Company and the Collateral Trustee, and as further amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on October 2, 2015 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on October 5, 2015 by the Company and the Collateral Trustee (as so amended and as otherwise amended from time to time prior to the date hereof, the " Stock Pledge Agreement "));

WHEREAS, pursuant to that certain senior secured second lien notes indenture, dated as of June 14, 2017, between THC Escrow Corporation III, a Delaware corporation (" Escrow Corp .") and The Bank of New York Mellon Trust Company, N.A., as trustee (the " Second Lien Trustee ") (the " Second Lien Base Indenture "), Escrow Corp. issued $1,410,000,000 principal amount of its 5.125% senior secured second lien notes due 2025 (the " Second Lien Notes "; the Second Lien Notes, collectively with any Securities of the Company issued and authenticated under the Junior Priority Indentures that are designated by the Company as, and are entitled the benefits of, being Junior Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof, the " Junior Lien Secured Notes ");

WHEREAS, pursuant to a supplemental indenture, dated as of July 14, 2017, to the Second Lien Base Indenture (the " Second Lien Supplemental Indenture " and, together with the Second Lien Base Indenture, the " Second Lien Indenture "), the Company assumed all obligations of the Escrow Corp. under the Second Lien Notes and the Second Lien Base Indenture;

WHEREAS, the Secured Obligations in respect of which a security interest in the Collateral was created by the Stock Pledge Agreement include the obligations in respect of the:

(a) Indenture, dated as of November 6, 2001 (the " Base Indenture "), between the Company and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, as trustee (in such capacity, the " Trustee ");

(b) Fourteenth Supplemental Indenture to the Base Indenture, dated as of November 21, 2011, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 6.250% Senior Secured Notes due 2018 (the " 2018 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Fourteenth Supplemental Indenture ");

(c) Fifteenth Supplemental Indenture to the Base Indenture, dated as of October 16, 2012, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.750% Senior Secured Notes due 2020 (the " 4.75% 2020 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Fifteenth Supplemental Indenture ");

(d) Seventeenth Supplemental Indenture to the Base Indenture, dated as of February 5, 2013, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.500% Senior Secured Notes due 2021 (the " 4.5% 2021 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Seventeenth Supplemental Indenture ");

(e) Twentieth Supplemental Indenture to the Base Indenture, dated as of May 30, 2013, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.375% Senior Secured Notes due 2021 (the " 4.375% 2021 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twentieth Supplemental Indenture ");

(f) Twenty-Eighth Supplemental Indenture to the Base Indenture, dated as of December 1, 2016, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 7.50% Senior Secured Second Lien Notes due 2022 (the " 7.50% 2022 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twenty-Eighth Supplemental Indenture ");

(g) Twenty-Ninth Supplemental Indenture to the Base Indenture, dated as of June 14, 2017, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.625% Senior Secured First Lien Notes due 2024 (the " 4.625% 2024 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twenty-Ninth Supplemental Indenture ");

(h) Indenture dated as of September 27, 2013 (the " 2013 Base Indenture "), between THC Escrow Corporation and the Trustee (as supplemented by the First Supplemental Indenture thereto, dated as of October 1, 2013, among the Company, the Trustee and the guarantors party thereto, the Second Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Third Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " 2013 Indenture ")), pursuant to which the 6.00% Senior Secured Notes due 2020 were issued (the " 6.000% 2020 Notes "; the 6.000% 2020 Notes, collectively with the 4.375% 2021 Notes, the 4.5% 2021 Notes, the 4.75% 2020 Notes and any other Securities (as such term is defined in the Base Indenture or the 2013 Base Indenture) of the Company issued and authenticated under the Indentures or the 2013 Indenture that are designated as, and are entitled to the benefits of, being First Priority Stock Secured Debt under the Collateral Trust Agreement

in accordance with the requirements set forth in Section 3.8 thereof, are referred to herein as the " First Lien Secured Notes "; the First Lien Secured Notes, together with the Junior Lien Secured Notes, are referred to herein as the " Secured Notes ");

(i) the Guarantees in respect of the Secured Notes; and

(j) the obligations under that certain Letter of Credit Facility Agreement, dated as of March 7, 2014 (as amended or otherwise modified, the " LC Facility Agreement "), among the Company, certain financial institutions party thereto from time to time as letter of credit participants and issuers and Barclays Bank PLC, as administrative agent, and the guarantees in respect thereof;

WHEREAS, subject to the terms and conditions hereof, the parties hereto desire to and have agreed to amend the Stock Pledge Agreement to secure the obligations in respect of the Junior Lien Secured Notes, in each case to be designated as and entitled to the benefits of being Junior Stock Secured Debt (as defined in the Collateral Trust Agreement) under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

WHEREAS, the sole effect of this Amendment is to secure additional debt of the Company that is permitted by the terms of the Collateral Trust Agreement to be secured by the Collateral and to add references to such debt and the documents governing such debt, and that as such, pursuant to:

(a) Section 7.1 of the Stock Pledge Agreement;

(b) Section 7.1 of the Collateral Trust Agreement;

(c) Article VII of each of the Fourteenth Supplemental Indenture, the Fifteenth Supplemental Indenture, Seventeenth Supplemental Indenture, Twentieth Supplemental Indenture, Twenty-Eighth Supplemental Indenture and Twenty-Ninth Supplemental Indenture and Section 902 of the 2013 Indenture; and

(d) Section 10.8 and 11.1 of the LC Facility Agreement, this Amendment may be entered into by the Company, the other pledgors party hereto and the Collateral Trustee without (i) the consent of the holders of the Notes or the holders of LC Obligations or (ii) direction to the Collateral Trustee by an Act of Required Stock Secured Debtholders (as defined in the Collateral Trust Agreement); and

WHEREAS, unless otherwise indicated, capitalized terms used herein without definition have the meanings ascribed to such terms in the Stock Pledge Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein contained, the Company and each other Pledgor signatory hereto hereby agrees with the Collateral Trustee as follows:

1. Section References . Unless otherwise expressly stated herein, all Section references herein shall refer to Sections of the Stock Pledge Agreement.

2. Amendments to Section 1.1 . Section 1.1 of the Stock Pledge Agreement is hereby amended by: (a) amending and restating the defined terms "2013 Indenture," "First Priority Supplemental Indentures," "Junior Lien Secured Notes," and "Junior Priority Indentures," in their entirety, and by adding the defined term "Sixth Amendment" in each case as set forth below (all other defined terms contained therein remain unchanged and to the extent that definitions contained in this Section 2 conflict with definitions contained in the Stock Pledge Agreement, the definitions contained in this Section 2 shall control):

" *2013 Indenture* " has the meaning specified in the Sixth Amendment.

" *First Priority Supplemental Indentures* " means the Fourteenth Supplemental Indenture, the Fifteenth Supplemental Indenture, the Seventeenth Supplemental Indenture, the Nineteenth Supplemental Indenture, the Twentieth Supplemental Indenture, the Twenty-Second Supplemental Indenture, the Twenty-Fifth Supplemental Indenture, the Twenty-Seventh Supplemental Indenture, and Twenty-Ninth Supplemental Indenture and all other indentures supplemental to the Base Indenture in respect of which Securities are issued and authenticated that are designated as and entitled to the benefits of being First-Priority Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

" *Junior Lien Secured Notes* " has the meaning specified in the Sixth Amendment.

" *Junior Priority Indentures* " means, collectively, the Base Indenture as severally supplemented by each Junior Priority Supplemental Indenture and the Second Lien Notes Indenture (as defined in the Sixth Amendment).

" *Sixth Amendment* " means the Sixth Amendment to Stock Pledge Agreement, dated as of July 14, 2017.

3. Conditions Precedent . The effectiveness of this Amendment is subject to the Collateral Trustee's receipt of each of the following: this Amendment, duly executed and delivered by the Company, each other Pledgor party hereto and the Collateral Trustee;

(a) an Officers' Certificate (as defined in the Collateral Trust Agreement) to the effect that this Amendment will not result in a breach of any provision or covenant contained in any of the Secured Debt Documents (as defined in the Collateral Trust Agreement); and

(b) an opinion of counsel of the Company to the effect that the Collateral Trustee's execution of this Amendment is authorized and permitted by the Collateral Trust Agreement.

4. Reference to Stock Pledge Agreement . The Stock Pledge Agreement and the Related Documents, and any and all other agreements, documents or instruments now or hereafter executed and/or delivered pursuant to the terms hereof or pursuant to the terms

of the Stock Pledge Agreement or the Related Documents, are hereby amended so that any reference therein to the Stock Pledge Agreement, whether direct or indirect, shall mean a reference to the Stock Pledge Agreement as amended hereby.

5. Counterparts . This Amendment may be executed by one or more of the parties to this Amendment on any number of separate counterparts (including by telecopy), each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Signature pages may be detached from multiple counterparts and attached to a single counterpart so that all signature pages are attached to the same document. Delivery of an executed counterpart by telecopy shall be effective as delivery of a manually executed counterpart.

6. Severability . Any provision of this Amendment that is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibitions or unenforceability without invalidating the remaining provisions hereof, and any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

7. Governing Law . THE INTERNAL LAW OF THE STATE OF NEW YORK SHALL GOVERN AND BE USED TO CONSTRUE THIS AMENDMENT WITHOUT GIVING EFFECT TO APPLICABLE PRINCIPLES OF CONFLICTS OF LAW TO THE EXTENT THAT THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION WOULD BE REQUIRED THEREBY.

8. Limited Effect . Except to the extent specifically amended or modified hereby, the provisions of the Stock Pledge Agreement shall not be amended, modified, impaired or otherwise affected hereby.

9. Responsibility of the Collateral Trustee . The Collateral Trustee is not responsible for the validity or sufficiency of this Amendment or the recitals contained herein. In no event shall the Collateral Trustee or Registrar (as defined in the Appointment of Registrar Letter dated March 23, 2015 between The Bank of New York Mellon Trust Company, N.A., as registrar (the " Registrar ") be charged with knowledge of the terms of, be subject to, or be required to comply with the LC Facility Agreement, or the Interim Loan Agreement, dated as of March 23, 2015, among the Company, the lenders thereto and Barclays Bank PLC, as administrative agent. All such responsibilities of the Collateral Trustee shall be as set forth in the Collateral Trust Agreement.

[*Signature Pages Follow*]

IN WITNESS WHEREOF, each of the undersigned has caused this Amendment to be duly executed and delivered as of the date first above written.

TENET HEALTHCARE CORPORATION, *as a Pledgor*

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Vice President and Assistant Treasurer

AMERICAN MEDICAL (CENTRAL), INC.
AMI INFORMATION SYSTEMS GROUP, INC.
AMISUB (HEIGHTS), INC.
AMISUB (HILTON HEAD), INC.
AMISUB (SFH), INC.
AMISUB (TWELVE OAKS), INC.
AMISUB OF NORTH CAROLINA, INC.
AMISUB OF SOUTH CAROLINA, INC.
AMISUB OF TEXAS, INC.
ANAHEIM MRI HOLDING, INC.
BROOKWOOD HEALTH SERVICES, INC.
CGH HOSPITAL, LTD., by: CORAL GABLES HOSPITAL, INC.,
as general partner COASTAL CAROLINA
MEDICAL CENTER, INC.
COMMUNITY HOSPITAL OF LOS GATOS, INC.
CORAL GABLES HOSPITAL, INC.
CYPRESS FAIRBANKS MEDICAL CENTER, INC.
DELRAY MEDICAL CENTER, INC.
DES PERES HOSPITAL, INC.
EAST COOPER COMMUNITY HOSPITAL, INC.
FMC MEDICAL, INC.
FOUNTAIN VALLEY REGIONAL HOSPITAL AND
MEDICAL CENTER
FRYE REGIONAL MEDICAL CENTER, INC.
GOOD SAMARITAN MEDICAL CENTER, INC.
HEALTHCARE NETWORK CFMC, INC.
HEALTHCARE NETWORK HOLDINGS, INC.
HEALTHCORP NETWORK, INC.
HEALTHCARE NETWORK LOUISIANA, INC.
HEALTHCARE NETWORK MISSOURI, INC.
HEALTHCARE NETWORK TEXAS, INC.
HEALTH SERVICES NETWORK HOSPITALS, INC.
HEALTH SERVICES NETWORK TEXAS, INC.
HIALEAH HOSPITAL, INC.
HILTON HEAD HEALTH SYSTEM, L.P., by:
TENET PHYSICIAN SERVICES — HILTON HEAD, INC., as general partner

HOSPITAL DEVELOPMENT OF WEST PHOENIX INC.
LIFEMARK HOSPITALS, INC.
LIFEMARK HOSPITALS OF FLORIDA, INC.
NEW MEDICAL HORIZONS II, LTD., by: CYPRESS FAIRBANKS MEDICAL CENTER INC., as general partner
NORTH SHORE MEDICAL CENTER, INC.
ORNDA HOSPITAL CORPORATION
PALM BEACH GARDENS COMMUNITY HOSPITAL, INC.
SAINT FRANCIS HOSPITAL— BARTLETT, INC.
SLH VISTA, INC.
SPALDING REGIONAL MEDICAL CENTER, INC.
SRRMC MANAGEMENT, INC.
ST. MARY'S MEDICAL CENTER INC.
SYLVAN GROVE HOSPITAL, INC.
TENET CALIFORNIA, INC.
TENET FLORIDA, INC.
TENET HEALTHSYSTEM HAHNEMANN, L.L.C., by: TENET HEALTHSYSTEM PHILADELPHIA, INC., as managing member
TENET HEALTHSYSTEM MEDICAL, INC.
TENET HEALTHSYSTEM PHILADELPHIA, INC.
TENET HEALTHSYSTEM ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN, L.L.C., by: TENET HEALTHSYSTEM PHILADELPHIA, INC., as managing member
TENET HOSPITALS LIMITED, by: HEALTHCARE NETWORK TEXAS, INC., as general partner
TENET PHYSICIAN SERVICES — HILTON HEAD, INC.
TH HEALTHCARE, LTD., by: LIFEMARK HOSPITALS, INC., as general partner
VHS ACQUISITION CORPORATION
VHS ACQUISITION SUBSIDIARY NUMBER 1, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 3, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 7, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 9, INC.
VHS BROWNSVILLE HOSPITAL COMPANY, LLC
WEST BOCA MEDICAL CENTER, INC.
VHS CHILDREN'S HOSPITAL OF MICHIGAN, INC.
VHS DETROIT RECEIVING HOSPITAL, INC.
VHS HARLINGEN HOSPITAL COMPANY, LLC
VHS HARPER-HUTZEL HOSPITAL, INC.
VHS HURON VALLEY-SINAI HOSPITAL, INC.
VHS OF ARROWHEAD, INC.
VHS OF ILLINOIS, INC.
VHS REHABILITATION INSTITUTE OF MICHIGAN, INC.
VHS SAN ANTONIO PARTNERS, LLC, by: VHS ACQUISITION SUBSIDIARY NUMBER 5, INC., its managing member, and VHS HOLDING COMPANY, INC.

VHS SINAI-GRACE HOSPITAL, INC.
VHS VALLEY MANAGEMENT COMPANY, INC.
VHS WEST SUBURBAN MEDICAL CENTER, INC.
VHS WESTLAKE HOSPITAL INC.
VHS OF PHOENIX, INC.
VANGUARD HEALTH FINANCIAL COMPANY, LLC
VANGUARD HEALTH HOLDING COMPANY I, LLC
VANGUARD HEALTH HOLDING COMPANY II, LLC
VANGUARD HEALTH MANAGEMENT, INC.
VANGUARD HEALTH SYSTEMS, INC.
VHS OF MICHIGAN, INC.

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Treasurer

BBH BMC, LLC
BROOKWOOD BAPTIST HEALTH 1, LLC
DESERT REGIONAL MEDICAL CENTER, INC.
DOCTORS HOSPITAL OF MANTECA, INC.
DOCTORS MEDICAL CENTER OF MODESTO, INC.
JFK MEMORIAL HOSPITAL, INC.
LAKEWOOD REGIONAL MEDICAL CENTER, INC.
LOS ALAMITOS MEDICAL CENTER, INC.
PLACENTIA-LINDA HOSPITAL, INC.
SAN RAMON REGIONAL MEDICAL CENTER, LLC
SIERRA VISTA HOSPITAL, INC.
TWIN CITIES COMMUNITY HOSPITAL, INC.
VHS VALLEY HEALTH SYSTEM, LLC

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Assistant Treasurer

ATLANTA MEDICAL CENTER, INC.
NORTH FULTON MEDICAL CENTER, INC.

By: /s/ William G. Morrison
Name: William G. Morrison
Title: Treasurer

ACCEPTED AND AGREED
as of the date first above written:

THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A.,
as Collateral Trustee

By: /s/ R. Tarnas
Name: R. Tarnas
Title: Vice President

Exhibit 10(o)

SEVENTH AMENDMENT TO STOCK PLEDGE AGREEMENT

This Seventh Amendment to Stock Pledge Agreement (this " Amendment ") is entered into as of February 5, 2019, among Tenet Healthcare Corporation, a Nevada corporation (the " Company "), each of the other entities listed on the signature pages hereof as Pledgors, and The Bank of New York Mellon Trust Company, N.A., as collateral trustee for the Secured Parties (in such capacity, the " Collateral Trustee ").

RECITALS

WHEREAS, reference is made to that certain Stock Pledge Agreement, dated as of March 3, 2009, among the Company, the other Pledgors and the Collateral Trustee (as amended by that certain First Amendment to Stock Pledge Agreement, dated as of May 8, 2009, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Second Amendment to Stock Pledge Agreement, dated as of June 15, 2009, among the Company, the other Pledgors and the Collateral Trustee, that certain Third Amendment to Stock Pledge Agreement, dated as of March 7, 2014, among the Company, the other Pledgors and the Collateral Trustee, that certain Fourth Amendment to Stock Pledge Agreement, dated as of March 23, 2015, among the Company, the other Pledgors and the Collateral Trustee, that certain Fifth Amendment to Stock Pledge Agreement, dated as of December 1, 2016, among the Company, the other Pledgors and the Collateral Trustee, and that certain Sixth Amendment to Stock Pledge Agreement, dated as of July 14, 2017, among the Company, the other Pledgors and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on May 15, 2013 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on May 15, 2013 by the Company and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on October 1, 2013 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on October 1, 2013 by the Company and the Collateral Trustee, as amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on March 23, 2015 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on March 23, 2015 by the Company and the Collateral Trustee, and as further amended by that certain Joinder Agreement to the Stock Pledge Agreement executed on October 2, 2015 by the other Pledgors and by that certain Pledge Amendment to the Stock Pledge Agreement executed on October 5, 2015 by the Company and the Collateral Trustee (as so amended and as otherwise amended from time to time prior to the date hereof, the " Stock Pledge Agreement "));

WHEREAS, pursuant to that certain Indenture, dated as of November 6, 2001 (the " Base Indenture "), between the Company and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, as trustee (in such capacity, the " Trustee "), as supplemented by the Thirtieth Supplemental Indenture thereto (the " Thirtieth Supplemental Indenture "), the Company has issued $1,500,000,000 principal amount of its 6.250% senior secured second lien notes due 2027 (the " 2027 Notes "; the 2027 Notes, collectively with the 2025 Notes (as defined below) and any other Securities of the Company issued and authenticated under the Junior Priority Indentures that are designated by the Company as, and are entitled the

benefits of, being Junior Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof, the " Junior Lien Secured Notes ");

WHEREAS, the Secured Obligations in respect of which a security interest in the Collateral was created by the Stock Pledge Agreement include the obligations in respect of the:

(a) Fifteenth Supplemental Indenture to the Base Indenture, dated as of October 16, 2012, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.750% Senior Secured Notes due 2020 (the " 4.75% 2020 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Fifteenth Supplemental Indenture ");

(b) Seventeenth Supplemental Indenture to the Base Indenture, dated as of February 5, 2013, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.500% Senior Secured Notes due 2021 (the " 4.5% 2021 Notes " and, as supplemented by the Nineteenth Supplemental Indenture, dated as of May 15, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Seventeenth Supplemental Indenture ");

(c) Twentieth Supplemental Indenture to the Base Indenture, dated as of May 30, 2013, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 4.375% Senior Secured Notes due 2021 (the " 4.375% 2021 Notes " and, as supplemented by the Twenty-Second Supplemental Indenture, dated as of October 1, 2013, between the Company, the Trustee and the guarantors party thereto, the Twenty-Fifth Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Twenty-Seventh Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " Twentieth Supplemental Indenture ");

(d) Twenty-Eighth Supplemental Indenture to the Base Indenture, dated as of December 1, 2016, by and among the Company, the Trustee and the guarantors party thereto and relating to the Company's 7.50% Senior Secured Second Lien Notes due 2022 (the " 7.50% 2022 Notes ") (the " Twenty-Eighth Supplemental Indenture ");

(e)Twenty-Ninth Supplemental Indenture to the Base Indenture, dated as of June 14, 2017, by and among the Company, the Trustee and the guarantors party thereto and

relating to the Company's 4.625% Senior Secured First Lien Notes due 2024 (the " 4.625% 2024 Notes ") (the " Twenty-Ninth Supplemental Indenture ");

(f) Indenture dated as of September 27, 2013 (the " 2013 Base Indenture "), between THC Escrow Corporation and the Trustee (as supplemented by the First Supplemental Indenture thereto, dated as of October 1, 2013, among the Company, the Trustee and the guarantors party thereto, the Second Supplemental Indenture thereto, dated as of March 23, 2015, among the Company, the Trustee and the guarantors party thereto, and the Third Supplemental Indenture thereto, dated as of October 2, 2015, among the Company, the Trustee and the guarantors party thereto, the " 2013 Indenture "), pursuant to which the 6.00% Senior Secured Notes due 2020 were issued (the " 6.000% 2020 Notes "; the 6.000% 2020 Notes, collectively with the 4.375% 2021 Notes, the 4.5% 2021 Notes, the 4.75% 2020 Notes, the 4.625% 2024 Notes and any other Securities (as such term is defined in the Base Indenture or the 2013 Base Indenture) of the Company issued and authenticated under the Indentures or the 2013 Indenture that are designated as, and are entitled to the benefits of, being First Priority Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof, are referred to herein as the " First Lien Secured Notes "; the First Lien Secured Notes, together with the Junior Lien Secured Notes, are referred to herein as the " Secured Notes ");

(g) Indenture dated as of June 14, 2017 (the " Second Lien Base Indenture "), between THC Escrow Corporation III and the Trustee (as supplemented by the Supplemental Indenture thereto, dated as of July 14, 2017, among the Company, the Trustee and the guarantors party thereto, the " Second Lien Indenture "), pursuant to which the 5.125% Senior Secured Second Lien Notes due 2025 were issued (the " 2025 Notes ");

(h) the Guarantees in respect of the Secured Notes; and

(i) the obligations under that certain Letter of Credit Facility Agreement, dated as of March 7, 2014 (as amended or otherwise modified, the " LC Facility Agreement "), among the Company, certain financial institutions party thereto from time to time as letter of credit participants and issuers and Barclays Bank PLC, as administrative agent, and the guarantees in respect thereof;

WHEREAS, subject to the terms and conditions hereof, the parties hereto desire to and have agreed to amend the Stock Pledge Agreement to secure the obligations in respect of the Junior Lien Secured Notes, in each case to be designated as and entitled to the benefits of being Junior Stock Secured Debt (as defined in the Collateral Trust Agreement) under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

WHEREAS, the sole effect of this Amendment is to secure additional debt of the Company that is permitted by the terms of the Collateral Trust Agreement to be secured by the Collateral and to add references to such debt and the documents governing such debt, and that as such, pursuant to:

(a) Section 7.1 of the Stock Pledge Agreement;

(b) Section 7.1 of the Collateral Trust Agreement;

(c) Article VII of each of the Fifteenth Supplemental Indenture, the Seventeenth Supplemental Indenture, the Twentieth Supplemental Indenture, the Twenty-Eighth Supplemental Indenture, the Twenty-Ninth Supplemental Indenture and the Thirtieth Supplemental Indenture, and Section 902 of each of the 2013 Indenture and the Second Lien Indenture; and

(d) Section 10.8 and 11.1 of the LC Facility Agreement, this Amendment may be entered into by the Company, the other pledgors party hereto and the Collateral Trustee without (i) the consent of the holders of the Notes or the holders of LC Obligations or (ii) direction to the Collateral Trustee by an Act of Required Stock Secured Debtholders (as defined in the Collateral Trust Agreement); and

WHEREAS, unless otherwise indicated, capitalized terms used herein without definition have the meanings ascribed to such terms in the Stock Pledge Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual covenants herein contained, the Company and each other Pledgor signatory hereto hereby agrees with the Collateral Trustee as follows:

1. Section References . Unless otherwise expressly stated herein, all Section references herein shall refer to Sections of the Stock Pledge Agreement.

2. Amendments to Section 1.1 . Section 1.1 of the Stock Pledge Agreement is hereby amended by: (a) amending and restating the defined terms "Junior Lien Secured Notes," "Junior Priority Indentures" and "Junior Priority Supplemental Indentures" in their entirety, and by adding the defined term "Seventh Amendment" in each case as set forth below (all other defined terms contained therein remain unchanged and to the extent that definitions contained in this Section 2 conflict with definitions contained in the Stock Pledge Agreement, the definitions contained in this Section 2 shall control):

"Junior Lien Secured Notes" has the meaning specified in the Seventh Amendment.

"Junior Priority Indentures" means, collectively, the Base Indenture as severally supplemented by each Junior Priority Supplemental Indenture and the Second Lien Indenture (as defined in the Seventh Amendment).

"Junior Priority Supplemental Indentures" means the Twenty-Eighth Supplemental Indenture, the Thirtieth Supplemental Indenture and all other indentures supplemental to the Base Indenture in respect of which Securities are issued and authenticated that are designated as, and entitled to the benefits of, being Junior Stock Secured Debt under the Collateral Trust Agreement in accordance with the requirements set forth in Section 3.8 thereof.

"Seventh Amendment" means the Seventh Amendment to Stock Pledge Agreement, dated as of February 5, 2019.

3. Conditions Precedent . The effectiveness of this Amendment is subject to the Collateral Trustee's receipt of each of the following:

(a) this Amendment, duly executed and delivered by the Company, each other Pledgor party hereto and the Collateral Trustee;

(b) an Officers' Certificate (as defined in the Collateral Trust Agreement) to the effect that this Amendment will not result in a breach of any provision or covenant contained in any of the Secured Debt Documents (as defined in the Collateral Trust Agreement); and

(c) an opinion of counsel of the Company to the effect that the Collateral Trustee's execution of this Amendment is authorized and permitted by the Collateral Trust Agreement.

4. Reference to Stock Pledge Agreement . The Stock Pledge Agreement and the Related Documents, and any and all other agreements, documents or instruments now or hereafter executed and/or delivered pursuant to the terms hereof or pursuant to the terms of the Stock Pledge Agreement or the Related Documents, are hereby amended so that any reference therein to the Stock Pledge Agreement, whether direct or indirect, shall mean a reference to the Stock Pledge Agreement as amended hereby.

5. Counterparts . This Amendment may be executed by one or more of the parties to this Amendment on any number of separate counterparts (including by telecopy), each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Signature pages may be detached from multiple counterparts and attached to a single counterpart so that all signature pages are attached to the same document. Delivery of an executed counterpart by telecopy shall be effective as delivery of a manually executed counterpart.

6. Severability . Any provision of this Amendment that is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibitions or unenforceability without invalidating the remaining provisions hereof, and any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

7. Governing Law . THE INTERNAL LAW OF THE STATE OF NEW YORK SHALL GOVERN AND BE USED TO CONSTRUE THIS AMENDMENT WITHOUT GIVING EFFECT TO APPLICABLE PRINCIPLES OF CONFLICTS OF LAW TO THE EXTENT THAT THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION WOULD BE REQUIRED THEREBY.

8. Limited Effect . Except to the extent specifically amended or modified hereby, the provisions of the Stock Pledge Agreement shall not be amended, modified, impaired or otherwise affected hereby.

9. Responsibility of the Collateral Trustee . The Collateral Trustee is not responsible for the validity or sufficiency of this Amendment or the recitals contained herein. In no event shall the Collateral Trustee or Registrar (as defined in the Appointment of Registrar Letter dated March 23, 2015 between The Bank of New York Mellon Trust Company, N.A., as registrar (the " Registrar ")) be charged with knowledge of the terms of, be subject to, or be required to comply with the LC Facility Agreement, or the Interim Loan Agreement, dated as of March 23, 2015, among the Company, the lenders thereto and Barclays Bank PLC, as administrative agent. All such responsibilities of the Collateral Trustee shall be as set forth in the Collateral Trust Agreement.

[Signature Pages Follow]

IN WITNESS WHEREOF, each of the undersigned has caused this Amendment to be duly executed and delivered as of the date first above written.

TENET HEALTHCARE CORPORATION, *as a Pledgor*

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Vice President and Treasurer

AMERICAN MEDICAL (CENTRAL), INC.
AMI INFORMATION SYSTEMS GROUP, INC.
AMISUB (HEIGHTS), INC.
AMISUB (HILTON HEAD), INC.
AMISUB (TWELVE OAKS), INC.
AMISUB OF TEXAS, INC.
BROOKWOOD HEALTH SERVICES, INC.
CORAL GABLES HOSPITAL, INC.
FMC MEDICAL, INC.
HEALTHCARE NETWORK CFMC, INC.
HEALTHCARE NETWORK HOLDINGS, INC.
HEALTHCARE NETWORK LOUISIANA, INC.
HEALTHCARE NETWORK MISSOURI, INC.
HEALTHCARE NETWORK TEXAS, INC.
HEALTHCORP NETWORK, INC.
HEALTH SERVICES CFMC, INC.
HEALTH SERVICES NETWORK HOSPITALS, INC.
HEALTH SERVICES NETWORK TEXAS, INC.
LIFEMARK HOSPITALS, INC.
ORNDA HOSPITAL CORPORATION
SRRMC MANAGEMENT, INC.
TENET CALIFORNIA, INC.
TENET FLORIDA, INC.
TENET HEALTHSYSTEM MEDICAL, INC.
TENET HEALTHSYSTEM PHILADELPHIA, INC.
TENET PHYSICIAN SERVICES – HILTON HEAD, INC.
VANGUARD HEALTH FINANCIAL COMPANY, LLC
VANGUARD HEALTH HOLDING COMPANY I, LLC
VANGUARD HEALTH HOLDING COMPANY II, LLC
VANGUARD HEALTH MANAGEMENT, INC.
VANGUARD HEALTH SYSTEMS, INC.
VHS OF PHOENIX, INC.
VHS OF MICHIGAN, INC.
VHS VALLEY MANAGEMENT COMPANY, INC.,
each as a Pledgor

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Vice President and Treasurer

BROOKWOOD BAPTIST HEALTH 1, LLC
VHS VALLEY HEALTH SYSTEM, LLC,
each as a Pledgor

By: /s/ James E. Snyder III
Name: James E. Snyder III
Title: Vice President and Treasurer

ACCEPTED AND AGREED
as of the date first above written:

THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A.,
as Collateral Trustee

By: /s/ R. Tarnas
Name: R. Tarnas
Title: Vice President

TENET

SEVENTH AMENDED AND RESTATED

EXECUTIVE RETIREMENT ACCOUNT

As Amended and Restated Effective as of April 1, 2018

SEVENTH AMENDED AND RESTATED
TENET EXECUTIVE RETIREMENT ACCOUNT

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SEVENTH AMENDED AND RESTATED
TENET EXECUTIVE RETIREMENT ACCOUNT

ARTICLE I
PREAMBLE AND PURPOSE

1.1 **Preamble.** Tenet Healthcare Corporation (the " **Company** ") established the Tenet Executive Retirement Account (the " **ERA** ") effective July 1, 2007, to permit the Company and its participating Affiliates, as defined herein (collectively, the " **Employer** "), to attract and retain a select group of management or highly compensated employees, as defined herein.

Through an instrument adopted in December 2008, the Company previously amended and restated the ERA, effective December 31, 2008, to (a) modify the fixed return investment option to provide that interest will be credited based on one hundred and twenty percent (120%) of the long-term applicable federal rate as opposed to the current provision which credited interest based on the prime rate of interest less one percent (1%), (b) revise the manner for determining vesting to years of plan participation. (c) reflect the right of the Pension Administration Committee to make non-material amendments to the ERA to comply with changes in the law or facilitate administration and (d) comply with final regulations issued under section 409A of the Internal Revenue Code of 1986, as amended (the " **Code** "). The amended and restated ERA was known as the First Amended and Restated Tenet Executive Retirement Account.

Through an instrument, adopted on December 11, 2009, the Company further amended and restated the ERA, also effective December 31, 2008, to clarify the ERA's intent to comply with section 409A of the Code; namely, to clarify that (a) ERA participants who incur a separation from service and are reemployed such that they do not have a break in employment under the Company's Rehire and Reinstatement Policy (or any successor thereto) will have any prior forfeited ERA account balance restored at the time of such reemployment (i.e., for consistency purposes, both the participant's prior years of service and account balance will be restored and administered on a going forward basis under the ERA) and (b) any subsequent deferral election made in accordance with the terms of the ERA will apply to an ERA participant's " **Normal Retirement Benefit** " (as defined herein). The amended and restated ERA was known as the Second Amended and Restated Tenet Executive Retirement Account,

Through an instrument adopted on July 21, 2011, the Company further amended and restated the ERA, effective May 3, 2011, to (a) provide that in the event of a Change of Control before July 1 of any year, the full Annual Contribution will be made to the ERA within ten (10) days following the occurrence of such Change of Control and (b) make other clarifying amendments to the ERA. The amended and restated ERA was known as the Third Amended and Restated Tenet Executive Retirement Account.

The Company subsequently amended and restated the ERA, effective as of May 9, 2012, to clarify certain Change of Control provisions; substitute a prorated payout for post Change of Control terminations, in place of the prior automatic post-Change of Control contributions;

and revise the definitions for certain termination events. The amended and restated ERA was known as the Fourth Amended and Restated Tenet Executive Retirement Account.

The Company further amended and restated the ERA, effective November 6, 2013 to (i) delegate to the Senior Vice President, Human Resources and the Plan Administrator the authority to determine the employees eligible to participate in the ERA and the amount of contribution each employee will receive, (ii) modify the definition of " **Year of Vesting Service** " to include service performed for an entity acquired by the Company through a stock, asset or other business transaction to the extent provided in the transaction documents or as determined by to the Senior Vice President, Human Resources or the Plan Administrator and (iii) clarify that a participant who is terminated for " **Cause** " will forfeit his ERA benefit in its entirety. By this restatement, the Company also desires to remove Conifer Health Solutions, LLC (" **Conifer** ") as a participating employer in the ERA effective as of December 31, 2013 except for prior Company employees who now work for Conifer and will be grandfathered. The amended and restated ERA was known as the Fifth Amended and Restated Tenet Executive Retirement Account.

Effective January 1, 2015, the Retirement Plans Administrative Committee (" **RPAC** ") amended the ERA to provide that an **"Affiliate** " as defined in the ERA will be determined based on an ownership percentage of greater than fifty percent (50%).

The RPAC further amended and restated the ERA effective November 30, 2015 to (i) incorporate the prior amendment to the ERA, (ii) delegate to the Senior Vice President, Human Resources and the Plan Administrator the authority to provide annual contributions and/or continued age and service credit for vesting purposes for any participant who transfers to an Affiliate who has not adopted the ERA as an Employer without the need for adoption of the ERA by such Affiliate, (iii) permit participants who are not participants in the " **SERP** ," as defined in Article II, who are ineligible or who become ineligible to participate in the ERA to receive earnings credit until they terminate employment with the Company and all Affiliates, and (iv) reflect that the name of the Compensation Committee has changed to the " **Human Resources Committee** ." The amended and restated ERA was known as the Sixth Amended and Restated ERA.

By this instrument the RPAC desires to further amend and restate the ERA effective April 1, 2018 to comply with the new ERISA regulations regarding Disability claims and make certain other administrative clarifications. This amended and restated ERA will be known as the Seventh Amended and Restated Tenet Executive Retirement Account.

The Employer may adopt one (1) or more domestic trusts to serve as a possible source of funds for the payment of benefits under this ERA.

1.2 **Purpose.** Through this ERA, the Employer intends to permit the deferral of compensation and to provide additional benefits to a select group of management or highly compensated employees of the Employer. Accordingly, it is intended that this ERA will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Code, nor will it constitute a "funded plan," for purposes of such requirements.

It also is intended that this ERA will be exempt from the participation and vesting requirements of Part 2 of Title I of the Employee Retirement Income Security Act of 1974,

as amended (" **ERISA** "). The funding requirements of Part 3 of Title I of ERISA, and the fiduciary requirements of Part 4 of Title I of ERISA by reason of the exclusions afforded plans that are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.1 Definitions. When a word or phrase appears in this ERA with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) " **Account** " means one (1) or more of the bookkeeping accounts maintained by the Company or its agent on behalf of a Participant, as described in more detail in Section 4.3. A Participant's Account may be divided into one or more " **Cash Accounts** " or " **Stock Unit Accounts** " as defined in Section 4.3.

(b) " **Affiliate** " means a corporation that is a member of a controlled group of corporations (as defined in section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is in common control (as defined in section 414(c) of the Code) with the Company, or any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company; provided, however that effective January 1, 2015, for purposes of determining if an entity is an Affiliate under sections 414(b) or (c) of the Code ownership will be determined based on an ownership percentage of greater than fifty percent (50%).

(c) " **Alternate Payee** " means any spouse, former spouse, child, or other dependent of a Participant who is recognized by a DRO as having a right to receive all, or a portion of the benefits payable under the ERA with respect to such Participant.

(d) " **Annual Contribution** " means the contribution made by the Employer on behalf of a Participant as described in Section 4.1(a).

(e) " **Beneficiary** " means the person designated by the Participant to receive a distribution of his benefits under the ERA upon the death of the Participant. If the Participant is married, his spouse will be his Beneficiary, unless his spouse consents in writing to the designation of an alternate Beneficiary. For this purpose, the term “spouse” means a Participant’s spouse under applicable state law, including effective August 3, 2011, a Participant's Domestic Partner as defined under the Criteria for Domestic Partnership Status under the Tenet Employee Benefit Plan, and effective September 16, 2013, a same sex spouse recognized as such in the state where the marriage is performed. In the event that a Participant fails to designate a Beneficiary, or if the Participant's Beneficiary does not survive the Participant, the Participant's Beneficiary will be his surviving spouse, if any, or if the Participant does not have a surviving spouse, his estate. The term " **Beneficiary** " also will mean a Participant's spouse or former spouse who is entitled to all or a portion of a Participant's benefit pursuant to Section 6.1.

(f) " **Board** " means the Board of Directors of the Company.

(g) " **Cause** " means

(i) For any event occurring on or within two (2) years after a Change of Control, the same meaning as set forth in Section 2.1(f)(ii) of the ESP.

(ii) For any Participant who is a Covered Executive under the Company's Executive Severance Plan, with respect to any event not occurring on or within two (2) years after a Change of Control, the same meaning as set forth in Section 2.1(f)(i) of the ESP.

(iii) for any Participant who is not a Covered Executive under the Company's Executive Severance Plan, with respect to any event not occurring on or within two (2) years after a Change of Control, the same meaning as set forth in Section 2.5(b)(ii) of the Stock Incentive Plan.

(h) " **Change of Control** " will have the meaning set forth in the ESP.

(i) " **Code** " means the Internal Revenue Code of 1986, as amended from time to time and any regulations and rulings issued thereunder.

(j) " **Compensation** " means the Participant's annual gross base salary including amounts reduced from the Participant's salary and contributed on the Participant's behalf as deferrals under any qualified or non-qualified employee benefit plans sponsored by the Employer or, to the extent provided in Section 4.1(a), an Affiliate. Compensation excludes bonuses, hardship withdrawal allowances, annual cash and/or stock bonuses, automobile allowances, housing allowances, relocation payments, deemed income, income payable under stock incentive plans, Christmas gifts, insurance premiums and other imputed income, pensions, and retirement benefits.

(k) " **Disability** " means the inability of a Participant to engage in any substantial gainful activity by reason of a mental or physical impairment expected to result in death or last for at least twelve (12) months, or the Participant, because of such a condition. is receiving income replacement benefits for at least three (3) months under an accident or health plan covering the Employer's employees.

(l) " **Discretionary Contribution** " means the contribution made by the Employer on behalf of a Participant as described in Section 4.1(b).

(m) " **DRO** " means a domestic relations order that is a judgment, decree, or order (including one that approves a property settlement agreement) that relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of a Participant and is made under a state (within the meaning of section 7701(a)(10) of the Code) domestic relations law (including a community property law) and that:

(i) Creates or recognizes the existence of an Alternate Payee's right to, or assigns to an Alternate Payee the right to receive all or a portion of the benefits payable with respect to a Participant under the ERA;

(ii) Does not require the ERA to provide any type or form of benefit, or any option, not otherwise provided under the ERA;

(iii) Does not require the ERA to provide increased benefits (determined on the basis of actuarial value);

(iv) Does not require the payment of benefits to an Alternate Payee that are required to be paid to another Alternate Payee under another order previously determined to be a DRO; and

(v) Clearly specifies: the name and last known mailing address of the Participant and of each Alternate Payee covered by the DRO; the amount or percentage of the Participant's benefits to be paid by the ERA to each such Alternate Payee, or the manner in which such amount or percentage is to be determined; the number of payments or payment periods to which such order applies; and that it is applicable with respect to this ERA.

For the avoidance of doubt, a DRO may be entered into with respect to a Participant who is not yet vested and may provide for the division of the Participant's benefits in the event the Participant becomes vested. For example, a DRO could provide that an Alternate Payee is entitled to 50% of the Participant's vested benefit as of the date the Participant attains age sixty-two (62). In this example, if the Participant does not vest by reason of attaining age sixty-two (62), the Alternate Payee would not be entitled to any portion of this benefit.

(n) " **Early Retirement Age** " means the date the Participant attains age fifty-five (55) and has completed ten (10) Years of Vesting Service.

(o) " **Early Retirement Benefit** " means the benefit payable to a Participant who has attained Early Retirement Age as provided in Section 5.2.

(p) " **Effective Date** " means April 1, 2018, except as provided otherwise herein.

(q) " **Eligible Person** " means an Employee who is designated as eligible to participate in the ERA by the Senior Vice President, Human Resources or the Plan Administrator or an Employee who satisfied the definition of Eligible Person in a prior ERA document and, in each case, who is not a participant in the SERP. As provided in Section 3.1 the RPAC may at any time, in its sole and absolute discretion, limit the classification of Employees who are eligible to participate in the ERA for a Plan Year and/or may modify or terminate an Eligible Person's participation in the ERA without the need for an amendment to the ERA.

(r) " **Employee** " means each select member of management or highly compensated employee receiving remuneration, or who is entitled to remuneration, for services provided to the Employer or an Affiliate, in the legal relationship of employer and employee.

(s) " **Employer** " means the Company and each Affiliate who with the consent of the Senior Vice President, Human Resources or Plan Administrator has adopted the ERA as a participating employer. An Affiliate may evidence its adoption of the ERA either by a formal action of its governing body or by commencing deferrals and taking other administrative actions with respect to this ERA on behalf of its employees. An entity will cease to be a participating employer as of the date such

entity ceases to be an Affiliate or the date specified by the Company. Effective December 31, 2013, Conifer Health Solutions, LLC ceased to be an Employer under the ERA with respect to all of its Employees except those specified in Exhibit A.

(t) " **Employment** " means any continuous period during which an employee is actively engaged in performing services for the Employer or, to the extent provided in Section 2.1(tt), an Affiliate, plus the term of any leave of absence approved by the Employer; provided, however, that if an employee takes an approved leave of absence and does not return to the employ of the Employer, such leave of absence will not count as Employment except as required by law.

(u) " **ERA** " means the Seventh Amended and Restated Tenet Executive Retirement Account as set forth herein and as the same may be amended from time to time.

(v) " **ERISA** " means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(w) " **ESP** " means the Tenet Executive Severance Plan, as amended from time to time.

(x) " **Fair Market Value** " means the closing price of a share of Stock on the New York Stock Exchange on the date as of which fair market value is to be determined.

(y) " **Five Percent Owner** " means any person who owns (or is considered as owning within the meaning of section 318 of the Code (as modified by section 416(i)(1)(B)(iii) of the Code)) more than five percent (5%) of the outstanding stock of the Company or an Affiliate or stock possessing more than five percent (5%) of the total combined voting power of all stock of the Company or an Affiliate. The rules of sections 414(b), (c) and (m) of the Code will not apply for purposes of applying these ownership rules. Thus, this ownership test will be applied separately with respect to the Company and each Affiliate.

(z) " **Good Reason** " means

(i) For an event occurring on or within two (2) years of a Change of Control, the same meaning as set forth in Section 2.1(x)(ii) of the ESP.

(ii) For any event not occurring on or within two (2) years after a Change of Control, the same meaning as set forth in Section 2.1(x)(i) of the ESP.

(aa) " **Human Resources Committee** " means the Human Resources Committee of the Board (including any predecessor or successor to such committee in name or form), which has the authority to amend and terminate the ERA as provided in Article X.

(bb) " **Inactive Participant** " means a Participant under this ERA who separates from Employment with the Employer or who is no longer or ceases to be an Eligible Person. Generally, no future contributions or earnings will be credited to an Inactive Participant's Account; provided, however, an Inactive Participant who is not a participant in the SERP will continue to have earnings credited to his Account on and after the Effective Date until he ceases employment with the Employer and all Affiliates.

(cc) " **Initial Enrollment Period** " means the thirty (30) day period immediately following the date the Eligible Person first becomes eligible to participate in the ERA during which the Eligible Person may elect the time at which to receive a distribution of Early Retirement Benefits pursuant to Section 3.1(b).

(dd) " **Involuntary Termination** " means:

(i) the Participant's Termination of Employment by the Employer without Cause, or

(ii) the Participant's resignation from Employment of the Employer for Good Reason;

provided, however, that an Involuntary Termination will not occur by reason of the divestiture of an Affiliate with respect to a Participant employed by such Affiliate who is offered a comparable position with the purchaser and either declines or accepts such position.

(ee) " **Key Employee** " means any employee or former employee (including any deceased employee) who at any time during the Plan Year was:

(i) an officer of the Company or an Affiliate having greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code for Plan Years beginning after December 31, 2002);

(ii) a Five Percent Owner; or

(iii) a One Percent Owner having compensation of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or One Percent Owner in accordance with section 1.415(c)-2(d)(4) of the Treasury Regulations (i.e., W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections) under section 132(f) of the Code (regarding qualified transportation fringe benefits) or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special timing rules and special rules set forth, respectively, in sections 1.415(c)-2(e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (i.e., the identification date). Employees that are Key Employees during such twelve (12) month period will be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (i.e., since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder.

For purposes of determining whether an employee or former employee is an officer, a Five Percent Owner or a One Percent Owner, the Company and each Affiliate will be treated as a separate employer (i.e., the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.1(ee)(i), compensation from the Company and all Affiliates will be taken into account (i.e., the controlled group rules of sections 414(b). (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.1(ee)(i), no more than fifty (50) employees of the Company or its Affiliates (i.e., the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50). the determination of which employees or former employees are officers will be determined based on who had the largest annual compensation from the Company and its Affiliates for the Plan Year. For the avoidance of doubt, for purposes of this Section 2.1(ee) the controlled group rules under sections 414(b) and (c) of the Code will be applied based on the normal ownership percentage of greater than eighty percent (80%) rather than the fifty percent (50%) standard used in the definition of Affiliate.

(ff) " **Normal Retirement Age** " means the date the Participant attains age sixty-two (62).

(gg) " **Normal Retirement Benefit** " means the benefit payable to a Participant at Normal Retirement Age pursuant to Section 5.1.

(hh) " **One Percent Owner** " means any person who would be described as a Five Percent Owner if "one percent (1%)" were substituted for "five percent (5%)" each place where it appears therein.

(ii) " **Other Termination** " means a Termination of Employment that is not an Involuntary Termination, including a Termination of Employment for Cause.

(jj) " **Participant** " means each Eligible Person who participates in this ERA and each Eligible Person or former Eligible Person whose participation in this ERA has not terminated.

(kk) " **Plan Administrator** " means the individual or entity appointed by the RPAC to handle the day-to-day administration of the ERA, including but not limited to determining an Employee's status as an Eligible Person, the Employee’s Annual Contribution amount, a Participant's eligibility for benefits and the amount of a Participant's benefits and complying with all applicable reporting and disclosure obligations imposed on the ERA. If the RPAC does not appoint an individual or entity as Plan Administrator, the RPAC will serve as the Plan Administrator.

(ll) " **Plan Year** " means the fiscal year of this ERA, which will commence on January 1 each year and end on December 31 of such year. The initial Plan Year was a short Plan Year beginning July 1, 2007 and ending December 31. 2007.

(mm) " **Retirement** " means a Termination of Employment on or after a Participant has attained Early Retirement Age or Normal Retirement Age.

(nn) " **RPAC** " means the Retirement Plans Administration Committee of the Company established by the Human Resources Committee, and whose members have been appointed by such Human Resources Committee or a delegate thereof. The RPAC will have the responsibility to administer the ERA and make final determinations regarding claims for benefits, as described in Article VIII.

(oo) " **SERP** " means the Tenet Healthcare Corporation Supplemental Executive Retirement Plan.

(pp) " **Stock** " means the common stock, par value $0.05 per share, of the Company.

(qq) " **Stock Unit** " means a non-voting, non-transferable unit of measurement that is deemed for bookkeeping and distribution purposes only to represent one outstanding share of Stock.

(rr) " **Stock Incentive Plan** " means the Tenet Healthcare 2008 Stock Incentive Plan, as amended from time to time.

(ss) " **Target Bonus** " means the target bonus percent applicable to the Participant under the Company's Annual Incentive Plan multiplied by his Compensation at the time of a Termination of Employment with the Employer. For example, if the Covered Executive earns one hundred and fifty thousand dollars ($150,000) and has a Target Bonus of fifty percent (50%), his Target Bonus equals seventy five thousand dollars ($75,000).

(tt) " **Termination of Employment** " means the date that a Participant ceases performing services for the Employer and its Affiliates in the capacity of an employee, or a reduction in Employment or other provision of services that qualifies as a separation from service under Section 409A of the Code. For this purpose a Participant who is on a leave of absence that exceeds six (6) months and who does not have statutory or contractual reemployment rights with respect to such leave, will be deemed to have incurred a Termination of Employment on the first day of the seventh (7th) month of such leave. A Participant who transfers Employment from an Employer to an Affiliate, regardless of whether such Affiliate has adopted the ERA as a participating employer, will not incur a Termination of Employment and such Participant may continue to be credited with Annual Contributions pursuant to Section 4.1(a) and/or accrue age and/or Years of Vesting Service pursuant to Section 2.1(ww). A Termination of Employment will either be an Involuntary Termination or an Other Termination.

(uu) " **Trust** " means the rabbi trust established with respect to the ERA the assets of which are to be used for the payment of benefits under the ERA.

(vv) " **Trustee** " means the individual or entity appointed to serve as trustee of any Trust established as a possible source of funds for the payment of benefits under this ERA as provided in Section 7.1. After the occurrence of a Change of Control, the

Trustee must be independent of any successor to the Company or any affiliate of such successor.

(ww) " **Year of Vesting Service** " means each complete Plan Year in which an Eligible Person is employed as an Employee of the Employer, beginning with the Plan Year in which the Participant commences participation in the ERA, and has an Account balance under the ERA. Such Plan Years will be referred to as "Years of Plan Participation" for purposes of this Section 2.1(ww). At the time an Eligible Person first becomes eligible to participate in the ERA, his prior complete years of continuous Employment with the Employer, commencing on the Eligible Person's date of Employment with the Employer in any capacity, will be converted to an equivalent number of complete Years of Plan Participation and count as Years of Vesting Service under the ERA.

In addition, service performed for an entity that is acquired by the Company through a stock, asset or other business transaction will be counted as Years of Vesting Service under the ERA to the extent provided in the transaction documents or as determined by the Senior Vice President, Human Resources or the Plan Administrator.

The Senior Vice President, Human Resources or the Plan Administrator may also credit a Participant who transfers to an Affiliate that is not an Employer with age and/or vesting service for employment with such Affiliate without the need for such Affiliate to adopt the ERA as an Employer.

An Eligible Person will not be given credit for partial Years of Plan Participation or partial years of Employment as Years of Vesting Service under the ERA. Further, to be counted as a Year of Vesting Service such Years of Plan Participation or years of Employment must be continuous.

In the event an Eligible Person incurs a Termination of Employment and is reemployed by the Employer within the time period required to prevent a break in Employment under the Company's Rehire and Reinstatement Policy (or any successor thereto), the provisions of which are incorporated herein by this reference:

(i) such Eligible Person's previously forfeited ERA Account balance will be restored at the time of such reemployment, and

(ii) his Years of Plan Participation or years of Employment completed before such reemployment will be treated as Years of Vesting Service under the ERA to the extent provided in such Rehire and Reinstatement Policy (or any successor thereto).

2.2 Construction. If any provision of this ERA is determined to be for any reason invalid or unenforceable, the remaining provisions of this ERA will continue in full force and effect.

All of the provisions of this ERA will be construed and enforced in accordance with the laws of the State of Texas and will be administered according to the laws of such state, except as otherwise required by ERISA, the Code or other applicable federal law.

The term "delivered to the RPAC or Plan Administrator," as used in this ERA, will include delivery to a person or persons designated by the RPAC or Plan Administrator, as applicable, for the disbursement and the receipt of administrative forms. Delivery will be deemed to have occurred only when the form or other communication is actually received.

Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of this ERA.

The pronouns "he," "him" and "his" used in the ERA will also refer to similar pronouns of the female gender unless otherwise qualified by the context.

2.3 409A Compliance. The ERA is intended to comply with the requirements of section 409A of the Code. The provisions of the ERA will be construed and administered in a manner that enables the ERA to comply with the provisions of section 409A of the Code.

End of Article II

ARTICLE III
PARTICIPATION AND FORFEITABILITY OF BENEFITS

3.1 Eligibility and Participation.

(a) **Determination of Eligibility** . An Employee who is designated as an Eligible Person by the Senior Vice President, Human Resources, or Plan Administrator will automatically become a Participant in the ERA as of the effective date of such designation. An Employee who was a Participant under the terms of a prior ERA document will continue participation on and after the Effective Date in accordance with the terms of this document.

(b) **Early Retirement Election** . An Eligible Person must elect during the Initial Enrollment Period whether he desires or does not desire to commence the distribution of the vested balance of his Account on the first day of the second calendar month following the date of his Retirement on or after attaining Early Retirement Age as provided pursuant to Section 5.2. If the Eligible Person fails to make this election during the Initial Enrollment Period, he will be deemed to have affirmatively elected to commence the distribution of the vested balance of his Account on the first day of the second calendar month following the date of his Retirement on or after attaining Early Retirement Age. Once made (or deemed made), this election cannot be revoked; however, the Participant may elect to defer payment of his vested Account balance pursuant to Section 5.7. Payment of such Early Retirement Benefit will be subject to the six (6) month restriction applicable to Key Employees, described in Section 5.4 of this ERA. The provisions of this Section 3.1(b) will apply to all Eligible Persons who are Employees on or after the Effective Date.

(c) **Limits on Eligibility** . The RPAC may at any time, in its sole and absolute discretion, limit the classification of Employees eligible to participate in the ERA and/or may limit or terminate an Eligible Person's participation in the ERA. Any action taken by the RPAC that limits the classification of Employees eligible to participate in the ERA or that modifies or terminates an Eligible Person's participation in the ERA will be set forth in Exhibit B attached hereto. Exhibit B may be modified from time to time without a formal amendment to the ERA. in which case a revised Exhibit B will be attached hereto.

(d) **Loss of Eligibility Status** . A Participant who becomes an Inactive Participant, under this ERA will retain such status until the Participant has received payment of any and all amounts payable to him under this ERA. An Inactive Participant who continues employment with an Affiliate who is not an Employer may continue to be credited with annual contributions pursuant to Section 4.1(a) and/or with age and/or Years of Vesting Service pursuant to Section 2.1(ww).

(e) **Subsequent SERP Participation** . A Participant's participation and Account balances will be frozen upon being named to the SERP (i.e., he will become an Inactive Participant and no additional contributions or earnings credits will be made); however, the Participant will continue to earn age and Years of Vesting Service for purposes of this ERA. Upon termination or retirement, the Participant will receive

his Account balance under the ERA pursuant to the terms hereof. In addition, the Participant will be entitled to receive a benefit from the SERP equal to the benefit accrued under the SERP as reduced by his benefit under the ERA. Distribution of the Participant's SERP benefit will be made pursuant to the terms of the SERP.

(f) **Initial SERP Participation** . A Participant who participated in the SERP before becoming a Participant in the ERA will be entitled to a benefit under this ERA, if any, equal to the amount of his Account. The Participant's accrued benefit under the SERP will be paid pursuant to the terms of the SERP and his benefit under this ERA, if any, will be paid pursuant to the terms hereof.

3.2 Forfeitability of Benefits. A Participant will forfeit any amounts credited to his Account as follows:

(a) **Other Termination** . Except as provided in section 4.2(a), if a Participant incurs an Other Termination before attaining age fifty-five (55), he will forfeit the entire balance of his Account. If a Participant incurs an Other Termination on or after attaining age fifty-five (55), he will forfeit the non-vested balance of his Account, as determined in accordance with Section 4.2(b) below.

(b) **Involuntary Termination.** If a Participant incurs an Involuntary Termination either before or on or after attaining age fifty-five (55), he will forfeit the non-vested balance of his Account. The vested balance of a Participant's Account in the event of an Involuntary Termination is determined in accordance with Section 4.2(c) (or, if applicable, Section 4.2(a)) below.

(c) **Cause** . If a Participant incurs a Termination of Employment for Cause, he will forfeit the entire balance, whether vested or not, of his Account.

End of Article III

ARTICLE IV
COMPANY CONTRIBUTIONS, VESTING, ACCOUNTING AND INVESTMENT CREDITING RATES

4.1 Company Contributions.

(a) **Annual Contribution** . The Company will make an Annual Contribution to the ERA each Plan Year on behalf of each Participant in an amount equal to ten percent (10%) of the Participant's Compensation unless the Senior Vice President, Human Resources or the Plan Administrator determine a different amount will apply and communicate that to the Participant in an offer letter or other communication. Unless declared otherwise by the Senior Vice President, Human Resources or the Plan Administrator, such Annual Contribution will be based on the Participant's Compensation on the date on which the Annual Contribution is made. In addition, in the case of Retirement on or after Normal Retirement Age, death, Disability, or an Involuntary Termination or change in position that results in the termination of active participation in the ERA without establishment of a successor plan within two (2) years after a Change of Control, a Participant will receive a prorated Annual Contribution based on the number of months during which he was employed from July 1 immediately preceding the applicable event.

The Senior Vice President, Human Resources or the Plan Administrator may credit a Participant who transfers to an Affiliate that is not an Employer with an Annual Contribution based on his Compensation with such Affiliate without the need for such Affiliate to adopt the ERA as an Employer.

(b) **Discretionary Contribution** . The Chief Executive Officer (or any successor title to such position) of the Company may declare that a Discretionary Contribution be made by the Employer to a Participant's Account in such amount, and at such time, as he may determine in his sole and absolute discretion.

4.2 Vesting in ERA Account.

(a) **Full Vesting Events** . A Participant will become one hundred percent (100%) vested in the balance of his Account upon the occurrence of any of the following events while an Employee:

(i) the Participant's attainment of age sixty (60) and completion of five (5) Years of Vesting Service;

(ii) the Participant's attainment of sixty-two (62) regardless of Years of Vesting Service;

(iii) the Participant's death;

(iv) the Participant's Disability; or

(v) the occurrence of a Change of Control.

(b) **Other Termination of Employment** . Except in the case of a Termination of Employment for Cause, a Participant who incurs an Other Termination before the

occurrence of a full vesting event described in Section 4.2(a) will vest in the balance of his Account pursuant to the following schedule:

Vesting Schedule for Other Termination										
Vesting (as a % of Account Balance)		Age								
		54 and Below	55	56	57	58	59	60	61	62
Whole Years of Service	4 or less	0%	0%							
	5		25%							
	6		30%							
	7		35%							
	8		40%							
	9		45%							
	10		50%							
	11		55%							
	12		60%							
	13		65%							
	14		70%							
	15		75%							
	16		80%							
	17		85%							
	18		90%							
	19		95%							
	20		100%							

The non-vested portion of the Participant's Account will be forfeited as of the date of his Termination of Employment (subject to the rules set forth in Section 2.1(ww) (regarding an individual who is reemployed before experiencing a break in employment under the Company's Rehire and Reinstatement Policy (or any successor thereto))).

In the case of a Termination of Employment for Cause, the Participant will forfeit the entire balance of his Account regardless if vested or not.

(c) **Involuntary Termination of Employment** . A Participant who incurs an Involuntary Termination before the occurrence of a full vesting event described in Section 4.2(a) will vest in the balance of his Account as follows:

Vesting Schedule for Involuntary Termination	
Years of Vesting Service	**Vested Percent**
4 or less	0%
5	25%
6	30%
7	35%
8	40%
9	45%
10	50%
11	55%
12	60%
13	65%
14	70%
15	75%
16	80%
17	85%
18	90%
19	95%
20	100%

The non-vested portion of the Participant's Account will be forfeited as of the date of his Termination of Employment.

4.3 Accounting for Deferred Compensation. The Plan Administrator will establish and maintain an individual Account or Accounts under the name of each Participant under the ERA. Depending on the Participant's selection of an investment crediting rate option pursuant to Section 4.4, the Plan Administrator may set up a Cash Account and/or a Stock Unit Account.

(a) **Cash Account** . If a Participant has made an election to have the balance of his Account to be deemed invested in a fixed rate of return or benchmark mutual funds pursuant to Section 4.4(a) or Section 4.4(b), the Company may, in its sole and absolute discretion, establish and maintain a Cash Account for the Participant under this ERA. Each Cash Account will be adjusted at least monthly to reflect the Annual Contributions and Discretionary Contributions credited thereto, earnings credited on such Annual Contributions and Discretionary Contributions pursuant to Section 4.4, and any payment of such Annual Contributions or Discretionary Contributions under this ERA. Such Annual Contributions and any Discretionary Contributions made on behalf of the Participant will be credited to each Participant's Cash Account at such times as determined by the Human Resources Committee. In the sole discretion of the Plan Administrator. more than one (1) Cash Account may be established for each Participant to facilitate record keeping convenience and accuracy.

(b) **Stock Unit Account** . If a Participant has made an election to have the balance of his Account to be deemed invested in Stock Units pursuant to Section 4.4(c), the Plan Administrator may, in its sole and absolute discretion. establish and maintain a Stock Unit Account and credit the Participant's Stock Unit Account with a number of Stock Units determined by dividing an amount equal to the Annual Contributions and Discretionary Contributions made on behalf of the Participant for a Plan Year

by the Fair Market Value of a share of Stock on the date such Contributions are made. Such Stock Units will be credited to the Participant's Stock Unit Account as soon as administratively practicable after the determination of the number of Stock Units is made pursuant to the preceding sentence. In the sole and absolute discretion of the Plan Administrator, more than one Stock Unit Account may be established for each Participant to facilitate record-keeping convenience and accuracy. Each such Stock Unit Account will be credited and adjusted as provided in this ERA.

The Stock Units credited to a Participant's Stock Unit Account will be used solely as a device for determining the number of shares of Stock eventually to be distributed to the Participant in accordance with this ERA. The Stock Units will not be treated as property of the Participant or as a trust fund of any kind. No Participant will be entitled to any voting or other stockholder rights with respect to Stock Units credited under this ERA.

If the outstanding shares of Stock are increased, decreased, or exchanged for a different number or kind of shares or other securities, or if additional shares or new or different shares or other securities are distributed with respect to such shares of Stock or other securities, through merger, consolidation, spin-off, sale of all or substantially all the assets of the Company, reorganization. recapitalization, reclassification, stock dividend, stock split, reverse stock split or other distribution with respect to such shares of Stock or other securities, an appropriate and proportionate adjustment will be made by the Human Resources Committee in the number and kind of Stock Units credited to a Participant's Stock Unit Account.

(c) **Unfunded Nature of Accounts** . Amounts credited to the Participant's Cash and Stock Unit Accounts will be held with the general assets of the Employer and, as provided in Section 7.2, will be subject to the claims of the Employer's general creditors. Establishment and maintenance of a separate Account or Accounts for each Participant will not be construed as giving any person any interest in assets of the Employer, or a right to payment other than as provided under this ERA. Such Accounts will be maintained until all amounts credited as to such Account have been distributed in accordance with the terms and provisions of this ERA.

4.4 Computation of Earnings Credited. The Participant may, pursuant to administrative procedures established by the RPAC, request the type of investment crediting rate option with which the Participant would like the Employer, in its sole and absolute discretion, to credit to the Participant's Account during the Participant's Employment. Such investment crediting rate election will apply to all contributions under the ERA; provided that no investment crediting will be made after the Participant incurs a Termination of Employment or transfers to an ineligible position, except as provided in Section 2,1(aa) (i.e., the Participant qualifies as an Inactive Participant who is not a participant in the SERP). To the extent the Participant has invested in Stock Units, upon his Termination of Employment or transfer to another position, the number of shares of Stock to which he is entitled will be determined and distributable to him pursuant to the terms of the ERA. For purposes of determining when a Participant incurs a Termination of Employment for investment crediting purposes, Employment will be deemed to have ceased on the last day of the calendar month of Employment.

The Participant will specify his preference from among the following possible investment crediting rate options:

(a) The annual rate of interest based on the benchmark money market mutual fund, compounded daily, such benchmark money market mutual fund will be for periods before October 1, 2008, the Fidelity Money Market Fund and from October 1, 2008, through December 31, 2008, an annual rate of interest equal to one percent (1%) below the prime rate of interest as quoted by Bloomberg, compounded daily, and effective on and after January 1, 2009, an annual rate of interest equal to one hundred and twenty percent (120%) of the long-term applicable federal rate. compounded daily;

(b) One (1) or more benchmark mutual funds; or

(c) Stock Units; provided that any request to have the Participant's Account to be deemed invested in Stock Units is irrevocable (i.e., a Participant may only change such investment election on a prospective basis) and such amounts will be distributed in an equivalent whole number of shares of Stock pursuant to the provisions of Article V. Any fractional share interests will be paid in cash with the last distribution.

During his Employment, the Participant may change, on a monthly basis, the investment crediting rate preference under this Section 4.4 by filing an election in such manner as will be determined by the RPAC. Notwithstanding any request made by a Participant, the Company will not be bound by such request and the Company, in its sole and absolute discretion, will determine the investment rate with which to credit amounts contributed on behalf of Participants under this ERA, provided, however, that if the Company chooses an investment crediting rate other than the investment crediting rate requested by the Participant, such investment crediting rate cannot be less than (a) above. If a Participant fails to set forth his investment crediting rate preference under this Section 4.4, he will be deemed to have elected the investment crediting rate in (a) above. The RPAC will select from time to time, in its sole and absolute discretion, the possible investment crediting rate options to be offered under the ERA.

End of Article IV

ARTICLE V
DISTRIBUTION OF BENEFITS

5.1 Normal Retirement Distribution. A Participant who remains in the employ of the Employer until his Normal Retirement Age will receive a Normal Retirement Benefit equal to the vested balance of his Account as of the date of his Retirement. Except as provided in Section 10.3, payment of the Normal Retirement Benefit will begin on the first day of the second calendar month following the date of the Participant's Retirement in the form of equal annual installments through the date the Participant attains age eighty (80). Distributions will be made in the form of cash or Stock, depending on the Participant's investment crediting rates as provided in Section 4.4. The commencement of payment of the Normal Retirement Benefit will be subject to the six (6) month delay applicable to Key Employees under Section 5.4. A Participant who is entitled to a Normal Retirement Benefit distribution may elect to defer payment of such distribution pursuant to Section 5.7.

5.2 Early Retirement Distribution. A Participant who remains in the employ of the Employer until his Early Retirement Age (and is not entitled to a distribution by reason of an Involuntary Termination pursuant to Section 5.3(a)) will receive an Early Retirement Benefit equal to the vested balance of his Account as of the date of his Retirement. Payment of the Early Retirement Benefit will begin on the first day of the second calendar month following the date of the Participant's Retirement; provided, that the Participant timely elected (or was deemed to have timely elected) to receive an Early Retirement Benefit pursuant to Section 3.1(b) and did not subsequently elect to defer such payment pursuant to Section 5.7. Except as provided in Section 10.3, distribution of the Early Retirement Benefit will be made in the form of equal annual installments through the date the Participant attains age eighty (80). Distributions will be made in the form of cash or Stock, depending on the Participant's investment crediting rates as provided in Section 4.4. The commencement of the payment of the Early Retirement benefit will be subject to the six (6) month delay applicable to Key Employees under Section 5.4.

5.3 Termination of Employment Distribution. A Participant who incurs a Termination of Employment for a reason other than Retirement, Disability or death, will receive a distribution of the vested balance of his Account, if any, pursuant to this Section 5.3. The commencement of the payment of the vested balance of the Participant's Account will be subject to the six (6) month delay applicable to Key Employees under Section 5.4.

(a) **Involuntary Termination Distribution** . If a Participant incurs an Involuntary Termination, he will receive payment of his vested Account balance, as determined in accordance with Section 4.2(c), commencing on the first day of the second calendar month following his attainment of age sixty-two (62) (regardless if the Participant has attained age fifty-five (55) and completed ten (10) Years of Vesting Service and has elected (or was deemed to have elected) an Early Retirement Benefit pursuant to Section 3.1(b)), unless he elected to defer payment pursuant to Section 5.7. Except as provided in Section 10.3, distribution of the Participant's vested Account balance will be made in equal annual installments through the date the Participant attains age eighty (80). Distributions will be made in the form of cash or Stock, depending on the Participant's investment crediting rates as provided in Section 4.4.

(b) **Other Termination Distribution** . Except in the case of a Termination of Employment for Cause, if a Participant incurs an Other Termination after attaining age fifty-five (55) and completing ten (10) Years of Vesting Service and the Participant elected (or was deemed to have elected) an Early Retirement Benefit pursuant to Section 3.1(b), distribution of the Participant's vested Account balance will be made pursuant to Section 5.2. If the Participant has not completed ten (10) Years of Vesting Service or did not elect (or was not deemed to have elected) an Early Retirement Benefit, distribution of the Participant's vested Account balance will commence on the first day of the second calendar month following the date he attains age sixty-two (62) unless he elected to defer payment pursuant to Section 5.7. Except as provided in Section 10.3, distribution of the Participant's vested Account balance will be made in the form of equal annual installments through the date the Participant attains age eighty (80). Distributions will be made in the form of cash or Stock, depending on the Participant's investment crediting rates as provided in Section 4.4.

A Participant who incurs a Termination of Employment for Cause will forfeit the entire balance of his Account regardless if vested.

5.4 Termination Distributions to Key Employees. Distributions under this ERA that are payable to a Key Employee on account of a Termination of Employment, including Retirement, will be delayed for a period of six (6) months following such Participant's Termination of Employment. This six (6) month restriction will not apply, or will cease to apply, with respect to a distribution to a Participant's Beneficiary by reason of the death of the Participant.

5.5 Death Distribution. In the event of the Participant's death, his vested Account balance will be distributed as follows:

(a) **Death While an Employee** . If the Participant dies while employed by the Employer, the Participant's vested Account balance, as determined pursuant to Section 4.2(a), will be paid to the Participant's Beneficiary in a lump sum, in cash and/or Stock depending on the Participant's investment crediting rates, by the later of the end of the Plan Year in which the Participant dies or ninety (90) days following the date of the Participant's death.

(b) **Death Following Termination** . If the Participant dies after his Termination of Employment while receiving installment payments from the ERA, the remaining amount of such installment payments will be paid to the Participant's Beneficiary in a lump sum, in cash and/or Stock depending on the Participant's investment crediting rates, by the later of the end of the Plan Year in which the Participant dies or ninety (90) days following the date of the Participant's death. If the Participant dies after his Termination of Employment before he begins receiving installment payments from the ERA, his vested Account balance will be paid in a to his Beneficiary in a lump sum, in cash and/or Stock depending on the Participant's investment crediting rates, by the later of the end of the Plan Year in which the Participant dies or ninety (90) days following the date of the Participant's death.

Amounts distributed pursuant to this Section 5.5 will not be subject to or, in the event installment payments to the Participant had already commenced at the time of the Participant's death, will cease to be subject to the six (6) month delay applicable to Key Employees under Section 5.4.

5.6 Disability Distribution. If a Participant incurs a Disability while employed by the Employer, distribution of his vested Account balance will begin on the first day of the second calendar month following the Participant's attainment of age sixty-five (65). Except as provided in Section 10.3, distribution of the Participant's vested Account will be made in the form of equal annual installments through the date the Participant attains age eighty (80). Distributions will be made in the form of cash or Stock, depending on the Participant's investment crediting rates as provided in Section 4.4. A Participant who is entitled to a Disability distribution may not elect to defer payment of such distribution pursuant to Section 5.7. Amounts distributed pursuant to this Section 5.6, will not be subject to the six (6) month delay applicable to Key Employees.

5.7 Deferral of Distributions. A Participant may elect to defer payment of his Normal Retirement Benefit payable pursuant to Section 5.1, his Early Retirement Benefit payable pursuant to Section 5.2 or a Termination of Employment distribution pursuant to Section 5.3 for a period of five (5) years from the date such payment would otherwise be made by making a deferral election at least twelve (12) months before the date payment would otherwise be made. In the event that the Participant becomes entitled to a distribution pursuant to Section 5.1, Section 5.2 or Section 5.3 during this twelve (12) month period, the deferral election will be of no effect and payment of the Participant's benefits will commence at the time specified in Section 5.1, Section 5.2 or Section 5.3, as applicable. A Participant who becomes entitled to distribution of a Disability benefit pursuant to Section 5.6 may not elect to defer payment of such distribution pursuant to this Section 5.7 and any deferral election made by such Participant will be null and of no effect.

5.8 Withholding. Any taxes or other legally required withholdings from distributions to Participants under the ERA will be deducted and withheld from the Participant's vested Accounts by the Employer, benefit provider or funding agent as required pursuant to applicable law. A Participant will be provided with a tax withholding election form for purposes of federal and state tax withholding, if applicable. A Beneficiary will be responsible for payment of his own federal, state and local taxes.

5.9 Impact of Reemployment on Benefits. If a Participant incurs a Termination of Employment and begins receiving, installment payments from the ERA and such Participant is reemployed by the Employer or an Affiliate, then such Participant's installment payments will continue as scheduled during the period of his reemployment.

End of Article V

ARTICLE VI
PAYMENT LIMITATIONS

6.1 Spousal Claims

(a) **Distribution of Benefit** . In the event that an Alternate Payee is entitled to all or a portion of a Participant's vested Account balance pursuant to the terms of a DRO, such amount will be paid to the Alternate Payee in a lump sum, in cash or Stock, based on the Participant's investment crediting rates under the ERA as provided in Section 4.4 and the terms of the DRO, within ninety (90) days after the Plan Administrator approves the DRO.

An Alternate Payee must complete and deliver to the Plan Administrator all required forms within thirty (30) days from the date the Alternate Payee is notified by the Plan Administrator that the DRO has been accepted. The Alternate Payee will be responsible for payment of any federal, state or local taxes.

(b) **Determination of Qualification of DRO** . The Plan Administrator will have sole and absolute discretion to determine whether a judgment, decree or order is a DRO, to determine whether a DRO will be accepted for purposes of this Section 6.1 and to make interpretations under this Section 6.1, including determining who is to receive benefits, the amount of such benefits, and the amount of taxes to be withheld. The decisions of the Plan Administrator will be binding on all parties with an interest.

(c) **Subject to ERA Provisions** . Any benefits payable to an Alternate Payee pursuant to the terms of a DRO will be subject to all provisions and restrictions of the ERA and any dispute regarding such benefits will be resolved pursuant to the ERA claims procedure in Article VIII.

6.2 Legal Disability. If a person entitled to any payment under this ERA is, in the sole judgment of the Plan Administrator, under a legal disability, or otherwise is unable to apply such payment to his own interest and advantage, the Plan Administrator, in the exercise of its discretion, may direct the Employer or payor of the benefit to make any such payment in any one (1) or more of the following ways:

(a) Directly to such person;

(b) To his legal guardian or conservator; or

(c) To his spouse or to any person charged with the duty of his support, to be expended for his benefit and/or that of his dependents.

The decision of the Plan Administrator will in each case be final and binding upon all persons in interest, unless the Plan Administrator reverses its decision due to changed circumstances.

6.3 Assignment. Except as provided in Section 6,1, no Participant or Beneficiary will have any right to assign, pledge, transfer, convey, hypothecate, anticipate or in any way create a lien on any amounts payable under this ERA. No amounts payable under this ERA will

be subject to assignment or transfer or otherwise be alienable, either by voluntary or involuntary act, or by operation of law, or subject to attachment, execution, garnishment, sequestration or other seizure under any legal, equitable or other process, or be liable in any way for the debts or defaults of Participants and their Beneficiaries.

End of Article VI

ARTICLE VII
FUNDING

7.1 No Right to Assets.

(a) **Employer Obligation** . Benefits under this ERA will be funded solely by the Employer. Benefits under this ERA will constitute an unfunded general obligation of the Employer, but the Employer may create reserves, funds and/or provide for amounts to be held in trust to fund such benefits on its behalf. Payment of benefits may be made by the Employer, any trust established by the Employer or through a service or benefit provider to the Employer or such trust. Upon the occurrence of a Change of Control, the Company will establish a rabbi trust to fund the benefits accrued under the ERA as of the date of the Change of Control.

(b) **Rabbi Trust** . Upon a Change of Control, the following will occur:

(i) the Trust will become (or continue to be) irrevocable;

(ii) for three (3) years following a Change of Control, the Trustee can only be removed as set forth in the Trust;

(iii) if the Trustee is removed or resigns within three (3) years following a Change of Control, the Trustee will select a successor Trustee, as set forth in the Trust;

(iv) for three (3) years following a Change of Control, the Company will be responsible for directly paying all Trustee fees and expenses, together with all fees and expenses incurred under Article VIII relating to the RPAC, Plan Administrator, and ERA administrative expenses (unless otherwise paid by the Trust from the Trust’s expense reserve); and

(v) the Trust Agreement may be amended only as set forth in the Trust (with the Trustee's consent); provided, however, that no such amendment will (A) change the irrevocable nature of the Trust; (B) adversely affect a Participant's rights to benefits under the ERA without the consent of the Participant; (C) impair the rights of the Company's creditors under the Trust; or (D) cause the Trust to fail to be a "grantor trust" pursuant to Code sections 671 through 679.

7.2 Creditor Status. Participants and their Beneficiaries will be general unsecured creditors of their respective Employer with respect to the payment of any benefit under this ERA, unless such benefits are provided under a contract of insurance or an annuity contract that has been delivered to Participants, in which case Participants and their Beneficiaries will look to the insurance carrier or annuity provider for payment, and not to the Employer. The Employer's obligation for such benefit will be discharged by the purchase and delivery of such annuity or insurance contract.

End of Article VII

ARTICLE VIII
ADMINISTRATION

8.1 The RPAC. The overall administration of the ERA will be the responsibility of the RPAC.

8.2 Powers of RPAC. The RPAC will have sole and absolute discretion regarding the exercise of its powers and duties under this ERA. In order to effectuate the purposes of the ERA, the RPAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the ERA;

(c) To construe the ERA and to make equitable adjustments for any mistakes or errors made in the administration of the ERA; and

(d) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the ERA and the trust established to secure the assets of the ERA when differences of opinion arise between the Company, an Affiliate, the Plan Administrator, the Trustee, a Participant, or any of them, and whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the ERA for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the RPAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the ERA.

8.3 Appointment of Plan Administrator. The RPAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the ERA on a daily basis. The RPAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the RPAC.

8.4 Duties of Plan Administrator. The Plan Administrator will have sole and absolute discretion regarding the exercise of its powers and duties under this ERA. The Plan Administrator will have the following powers and duties:

(a) To direct the administration of the ERA in accordance with the provisions herein set forth;

(b) To adopt rules of procedure and regulations necessary for the administration of the ERA, provided such rules are not inconsistent with the terms of the ERA:

(c) To determine all questions with regard to rights of Employees. Participants, and Beneficiaries under the ERA including, but not limited to, questions involving eligibility of an Employee to participate in the ERA, the amount of a Participant’s Annual Contribution and the value of a Participant's vested Account:

(d) To enforce the terms of the ERA and any rules and regulations adopted by the RPAC;

(e) To review and render decisions respecting a claim for a benefit under the ERA;

(f) To furnish the Employer with information that the Employer may require for tax or other purposes;

(g) To engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) To prescribe procedures to be followed by Participants in obtaining benefits;

(i) To receive from the Employer and from Participants such information as is necessary for the proper administration of the ERA;

(j) To establish and maintain, or cause to be maintained, the individual Accounts described in Section 4.3;

(k) To create and maintain such records and forms as are required for the efficient administration of the ERA;

(l) To make all determinations and computations concerning the benefits, credits and debits to which any Participant, or other Beneficiary, is entitled under the ERA;

(m) To give the Trustee of the trust established to serve as a source of funds under the ERA specific directions in writing with respect to:

(i) making distribution payments, giving the names of the payees, specifying the amounts to be paid and the time or times when payments will be made; and

(ii) making any other payments which the Trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator;

(n) To comply with all applicable lawful reporting and disclosure requirements of ERISA;

(o) To comply (or transfer responsibility for compliance to the Trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(p) To construe the ERA, in its sole and absolute discretion, and make equitable adjustments for any errors made in the administration of the ERA.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the ERA.

8.5 Indemnification of RPAC and Plan Administrator. To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations. the Employer agrees to hold harmless and indemnify the RPAC and Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising out of any act or omission relating to or in connection with the ERA other than losses resulting from the RPAC's, or any such person's commission of fraud or willful misconduct.

8.6 Claims for Benefits.

(a) **Initial Claim** . In the event that an Employee, Eligible Person, Participant or his Beneficiary (a " **claimant** ") claims to be eligible for benefits, or claims any rights under this ERA, such claimant must complete and submit such claim forms and supporting documentation as will be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any claimant who feels unfairly treated as a result of the administration of the ERA must file a written claim. setting forth the basis of the claim, with the Plan Administrator. In connection with the determination of a claim, or in connection with appeal of a denied claim. the claimant may examine this ERA, and any other pertinent documents generally available to Participants that are specifically related to the claim and may appoint an authorized representative to pursue the claim on his behalf. References to the claimant include his authorized representative, when applicable.

Different claims procedures apply to claims for benefits on account of Disability, referred to as "Disability claims," and all other claims for benefits, referred to as "non-Disability claims "

(b) **Non-Disability Claims.**

(i) **Initial Decision on Non-Disability Claim** . If a claimant files a non-Disability claim, written notice of the disposition of such claim will be furnished to the claimant within ninety (90) days after the claim is filed with the Plan Administrator unless special circumstances require an extension of time for processing the claim. Such extension will not exceed ninety (90) days and no extension will be allowed unless, within the initial ninety (90)-day period, the claimant is sent an extension notice indicating the special circumstances requiring the extension and specifying a date by which the Plan Administrator expects to issue its final decision. If the claim is denied, the Plan Administrator's notice will set forth:

(A) The specific reason or reasons for the denial;

(B) Specific references to pertinent ERA provisions on which the Plan Administrator based its denial;

(C) A description of any additional material and information needed for the claimant to perfect his claim and an explanation of why the material or information is needed;

(D) A statement that the claimant may:

(1) Appeal the claim in writing to the RPAC, including a description of such appeal procedures and the time limits applicable to such procedures;

(2) Review pertinent ERA documents;

(3) Submit issues and comments in writing; and

(4) Pursue arbitration following the denial of the claim on appeal;

(E) A statement that any appeal that the claimant wishes to make of the adverse determination must be made in writing to the RPAC within ninety (90) days after receipt of the Plan Administrator's notice of denial of benefits; and

(F) A statement that his failure to appeal the action to the RPAC in writing within the ninety (90)-day period will render the Plan Administrator's determination final, binding, and conclusive.

All benefits provided in this ERA as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(ii) **Appeal of Denied Non-Disability Claim** . Within ninety (90) days after receiving written notice of the Plan Administrator's denial of his initial non-Disability claim, the claimant may file with the RPAC a written appeal of his claim. If the claimant does not file an appeal within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant will be deemed to have accepted the Plan Administrator's written disposition, unless the claimant was physically or mentally incapacitated so as to be unable to file an appeal within the ninety (90) day period.

(iii) **Decision on Appeal of Non-Disability Claim** . After receipt by the RPAC of a written appeal of a non-Disability claim, the RPAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The RPAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on appeal of the claim will be made by the RPAC at its next meeting following receipt of the appeal. If no meeting of the RPAC is scheduled within forty-five (45) days of receipt of the appeal, then the RPAC will hold a special meeting to review such appeal within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be made within ninety (90) days of receipt of the appeal. In any event, if a claim is not determined by the RPAC within ninety (90) days of receipt of the appeal, it will be deemed to be denied.

The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the determination on appeal is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant ERA provisions on which the decision was based. Such decision will also advise the claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the RPAC will be final and conclusive.

(c) **Disability Claims.** The ERA will ensure that all Disability claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision by ensuring that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, such as a medical or vocational expert, must not be based upon the likelihood that the individual will support the denial of benefits.

(i) **Initial Decision on Disability Claim** . The Plan Administrator will notify the claimant the initial decision on a Disability claim no later than forty-five (45)-days after receipt of the claim by the Plan. This period may be extended by the Plan Administrator for up to thirty (30) days provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the ERA and the claimant is notified before the expiration of the initial forty-five (45)-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to make a decision. If, before the first thirty (30)-day extension period, the Plan Administrator determines that, due to matters beyond the control of the ERA, a decision can not be made within that extension period, the period for making the initial benefit determination may be extended for up to an additional thirty (30) days provided that the claimant is notified before the expiration of the first thirty (30)-day extension period of the circumstances requiring the extension and the date as of which the Plan Administrator expects to issue a decision. In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a benefit by reason of Disability is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues and the claimant will be given at least forty-five (45) days within which to provide the specified information.

The claimant will be provided with written or electronic notification of any adverse benefit determination (i.e., denial) of a disability claim, in a culturally and linguistically appropriate manner by providing oral language services (such as a telephone customer assistance hotline) that includes answering questions in any “applicable non-English language,” as defined below, and providing assistance with filing claims and appeals in any applicable non-English language, providing, upon request, a notice in any applicable non-English language and including in the English version of all notices, a

statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the ERA. For this purpose a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county to which a notice is sent is literate only in the same non-English language, as determined in guidance issued by the Secretary of the Department of Labor. The notification will set forth, in a manner calculated to be understood by the claimant:

(A) the specific reason or reasons for the denial;

(B) reference to the specific ERA provisions on which the denial is based;

(C) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(D) a description of the ERA's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502 of ERISA following the denial of an appeal;

(E) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the ERA of health care professionals treating the claimant and the vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the ERA in connection with the denial, without regard to whether the advice was relied on in making the benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the ERA made by the Social Security Administration;

(F) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the ERA to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(G) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the ERA relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

(H) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

(ii) **Appeal of Denial of Disability Claim**

(A) **Opportunity for Full and Fair Review** . A claimant will be provided a reasonable opportunity to appeal the denial of his Disability claim under which there will be a full and fair review of the claim and the denial. Accordingly:

(1) a claimant will be provided one hundred and eighty (180) days following receipt of notice of the denial of the Disability claim to appeal such determination;

(2) a claimant will be provided the opportunity to submit written comments, documents, records or other information relating to the Disability claim on appeal;

(3) a claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Disability claim;

(4) appellant review will take into account all comments, documents, records and other information submitted by the claimant relating to the Disability claim without regard to other such information once submitted or considered in the initial benefit determination;

(5) such appeal will not afford deference to the initial denial and will be conducted by the RPAC, which is an appropriate Named Fiduciary of the ERA and which will neither be the individual who denied the Disability claim that is subject to the appeal nor the subordinate of such individual;

(6) in the case of any appeal of a denied Disability claim that is based in whole or in part on a medical judgment, the claimant will be entitled to a review by the RPAC based on the RPAC's consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment whereby such professional is neither an individual who was consulted in connection with the denial that is the subject of the appeal nor the subordinate of any such individual;

(7) the claimant will be provided with the identity of the medical or vocational experts whose advice was obtained on behalf of the ERA in connection with the denial of the Disability claim, without regard to whether the advice was relied upon in making the benefit determination; and

(8) as soon as possible and sufficiently in advance of the date on which the notice on the appeal is required to be provided, the RPAC or its delegate will provide the claimant, free of charge, with any new or additional evidence and/or rationale

considered, relied upon, or generated by the ERA in connection with the Disability claim.

(B) **Timing of Decision on Appeal of Disability Claim** . The decision on appeal of the claim will be made by the RPAC at its next meeting following receipt of the appeal. If no meeting of the RPAC is scheduled within forty-five (45) days of receipt of the appeal, then the RPAC will hold a special meeting to review such appeal within such forty-five (45) day period. If special circumstances require an extension of the forty-five (45) day period, the RPAC will so notify the claimant and a decision will be made within ninety (90) days of receipt of the appeal. In any event, if the appeal is not determined by the RPAC within ninety (90) days after its receipt of the appeal, it will be deemed to be denied.

(C) **Decision on Appeal of Disability Claim** . The decision of the RPAC will be provided to the claimant as soon as possible but no later than five (5) days after the determination on appeal is made. The claimant will be provided with written or electronic notification of the ERA's benefit determination on appeal in a culturally and linguistically appropriate manner by providing oral language services (such as a telephone customer assistance hotline) that includes answering questions in any "applicable non-English language," as defined below, and providing assistance with filing claims and appeals in any applicable non-English language, providing, upon request, a notice in any applicable non-English language and including in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the ERA. For this purpose a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county to which a notice is sent is literate only in the same non-English language, as determined in guidance issued by the Secretary of the Department of Labor. If the appeal is denied, the notification will set forth, in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the appeal decision;

(2) reference to the specific ERA provisions on which the appeal decision is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Disability claim for benefits;

(4) a statement describing the ERA's appeals procedures, the right to obtain information about such procedures, a statement of the claimant's right to file a civil action under

section 502 of ERISA including a description of any applicable contractual limitations period that applies to the claimant's right to bring such action, including the date on which the contractual limitations period expires for the claim;

(5) a discussion of the appeal decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the ERA of health care professionals treating the claimant and the vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the ERA in connection with the claimant's appeal, without regard to whether the advice was relied on in denying the appeal, and (iii) a disability determination regarding the claimant presented by the claimant to the ERA made by the Social Security Administration;

(6) if the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial on appeal, applying the terms of the ERA to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the ERA relied upon in denying the appeal or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

8.7 **Arbitration.** In the event the claims review procedure described in Section 8.6 of the ERA with respect to non-Disability claims does not result in an outcome thought by the claimant to be in accordance with the ERA document, he may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within sixty (60) days after receiving the RPAC's denial or deemed denial of his request for review and before bringing suit in court. The arbitration will be conducted pursuant to the American Arbitration Association (" **AAA** ") Rules on Employee Benefit Claims.

The arbitrator will be mutually selected by the claimant and the RPAC from a list of arbitrators who are experienced in nonqualified deferred compensation plan benefit matters that is provided by the AAA. If the parties are unable to agree on the selection of an arbitrator within ten (10) days of receiving the list from the AAA, the AAA will appoint an arbitrator. The arbitrator's review will be limited to interpretation of the ERA document in the context of the particular facts involved. The claimant, 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 claimant, 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 claimant or witness costs for the claimant will be borne by the claimant; provided, that, as part of his award, the Arbitrator may require the Company to reimburse the claimant for all or a portion of such amounts.

The following discovery may be conducted by the parties: interrogatories, demands to produce documents, requests for admissions and oral depositions. The arbitrator will resolve any discovery disputes by such pre hearing conferences as may be needed. The Company, RPAC and claimant agree that the arbitrator will have the power of subpoena process as provided by law. Disagreements concerning the scope of depositions or document production, its reasonableness and enforcement of discovery requests will be subject to agreement by the Company and the claimant or will be resolved by the arbitrator. All discovery requests will be subject to the proprietary rights and rights of privilege and other protections granted by applicable law to the Company and the claimant and the arbitrator will adopt procedures to protect such rights. With respect to any dispute, the Company, RPAC and the claimant agree that all discovery activities will be expressly limited to matters directly relevant to the dispute and the arbitrator will be required to fully enforce this requirement.

The arbitrator will have no power to add to, subtract from, or modify any of the terms of the ERA, or to change or add to any benefits provided by the ERA, or to waive or fail to apply any requirements of eligibility for a benefit under the ERA. Nonetheless, the arbitrator will have absolute discretion in the exercise of its powers in this ERA. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the ERA.

8.8 Receipt and Release of Necessary Information. In implementing the terms of this ERA, the RPAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the RPAC or Plan Administrator deems to be necessary for such purposes. Any Participant or Beneficiary claiming benefits under this ERA will furnish to the RPAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

8.9 Overpayment and Underpayment of Benefits. The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Participant or Beneficiary receives an underpayment of benefits. the Plan Administrator will direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Participant or Beneficiary. for whatever reason, the Plan Administrator may, in its sole and absolute discretion, (a) withhold payment of any further benefits under the ERA until the overpayment has been collected; provided, that the entire amount of reduction in any calendar year does not exceed five thousand dollars ($5,000), and the reduction is made at the same time and in the same amount as the debt otherwise would have been due and collected from the Participant, or (b) may require repayment of benefits paid under this ERA without regard to further benefits to which the Participant or Beneficiary may be entitled.

8.10 Change of Control. Upon a Change of Control and for the following three (3) years thereafter, if any arbitration arises relating to an event occurring or a claim made within

three (3) years of a Change of Control, (i) the arbitrator will not decide the claim based on an abuse of discretion principle or give the previous RPAC decision any special deference, but rather will determine the claim de novo based on its own independent reading of the ERA; and (ii) the Company will pay the Participant's reasonable legal and other related fees and expenses, by applying Section 3.1(f) of the ESP (except that if the Participant is not entitled to severance benefits under the ESP on account of the Termination of Employment that entitles the Participant to receive benefits under this ERA, the reference to the "shorter of the Severance Period or the Reimbursement Period" in the ESP will be changed to the "Reimbursement Period" only).

End of Article VIII

ARTICLE IX
OTHER BENEFIT PLANS OF THE COMPANY

9.1 **Other Plans.** Nothing contained in this ERA will prevent a Participant before his death, or a Participant's spouse or other Beneficiary after such Participant's death, from receiving, in addition to any payments provided for under this ERA, any payments provided for under any other plan or benefit program of the Employer or an Affiliate, or which would otherwise be payable or distributable to him, his surviving spouse or Beneficiary under any plan or policy of the Employer, an Affiliate or otherwise. Nothing in this ERA will be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees. Unless otherwise specifically provided in any plan of the Company intended to "qualify" under section 401 of the Code, Compensation made under this ERA will constitute earnings or compensation for purposes of determining contributions or benefits under such qualified plan.

End of Article IX

ARTICLE X
AMENDMENT AND TERMINATION OF THE PLAN

10.1 Continuation. The Company intends to continue this ERA indefinitely, but nevertheless assumes no contractual obligation beyond the promise to pay the benefits described in this ERA.

10.2 Amendment of ERA. The Company, through an action of the Human Resources Committee, reserves the right in its sole and absolute discretion to amend this ERA in any respect at any time, except that upon or during the two (2) year period after any Change of Control of the Company, (a) ERA benefits cannot be reduced, (b) Articles VIII and X and Section 7.1(b) cannot be changed, and (c) (except as provided in Section 10.3) no prospective amendment that adversely affects the rights or obligations of a Participant may be made unless the affected Participant receives at least one (1) year's advance written notice of such amendment.

Moreover, no amendment may ever be made that retroactively reduces or diminishes the rights of any Participant to the benefits described herein that have been accrued or earned through the date of such amendment, even if a Termination of Employment has not yet occurred with respect to such Participant.

In addition to the Human Resources Committee, the RPAC has the right to make non-material amendments to the ERA to comply with changes in the law or to facilitate ERA administration; provided, however, that each such proposed non¬-material amendment must be discussed with the Chairperson of the Human Resources Committee in order to determine whether such change would constitute a material amendment to the ERA.

The provisions of this Section 10.2 will not restrict the right of the Company to terminate this ERA under Section 10.3 below or the termination of an Affiliate’s participation under Section 10.4 below.

10.3 Termination of ERA. The Company, through an action of the Human Resources Committee, may terminate or suspend this ERA in whole or in part at any time, provided that no such termination or suspension will deprive a Participant, or person claiming benefits under this ERA through a Participant, of any amount credited to his Account under this ERA up to the date of suspension or termination. Except as required by applicable law and pursuant to the valuation of such Account pursuant to Section 4.4, the Human Resources Committee may decide to liquidate the ERA upon termination under the following circumstances:

(a) **Corporate Dissolution or Bankruptcy** . The Human Resources Committee may terminate and liquidate the ERA within twelve (12) months of a corporate dissolution taxed under section 331 of the Code or with the approval of a bankruptcy court pursuant to 11 U.S.C. § 503(b)(1)(A); provided, that the amounts deferred under the ERA are included in Participants' gross income in the latest of the following years (or if earlier, the taxable year in which the amount is actually or constructively received):

(i) The calendar year in which the ERA termination and liquidation occurs.

(ii) The first calendar year in which the amount is no longer subject to a substantial risk of forfeiture.

(iii) The first calendar year in which the payment is administratively practicable.

(b) **Change in Control** . The Human Resources Committee may terminate and liquidate the ERA within the thirty (30) days preceding or the twelve (12) months following a Change in Control (except on account of a liquidation or dissolution of the Company), provided that all plans or arrangements that would be aggregated with the ERA under section 409A of the Code are also terminated and liquidated with respect to each Participant that experienced the Change in Control event so that under the terms of the ERA and all such arrangements the Participant is required to receive all amounts of compensation deferred under such arrangements within twelve (12) months of the termination of the ERA or arrangement, as applicable. In the case of a Change of Control event which constitutes a sale of assets, the termination of the ERA pursuant to this Section 10.3(b) may be made with respect to the Employer that is primarily liable immediately after the Change of Control transaction for the payment of benefits under the ERA.

(c) **Termination of ERA** . The Human Resources Committee may terminate and liquidate the ERA provided that (i) the termination and liquidation does not occur by reason of a downturn of the financial health of the Company or an Employer, (ii) all plans all plans or arrangements that would be aggregated with the ERA under section 409A of the Code are also terminated and liquidated, (iii) no payments in liquidation of the ERA are made within twelve (12) months of the date of termination of the ERA other than payments that would be made in the ordinary course operation of the ERA, (iv) all payments are made within twenty-four (24) months of the date the ERA is terminated and (v) the Company or the Employer, as applicable depending on whether the ERA is terminated with respect to such entity, do not adopt a new plan that would be aggregated with the ERA within three (3) years of the date of the termination of the ERA.

10.4 Termination of Affiliate's Participation. An Affiliate may terminate its participation in the ERA at any time by an action of its governing body and providing written notice to the Company. Likewise, the Company may terminate an Affiliate's participation in the ERA at any time by an action of the Human Resources Committee and providing written notice to the Affiliate. The effective date of any such termination will be the later of the date specified in the notice of the termination of participation or the date on which the RPAC can administratively implement such termination. In the event that an Affiliate's participation in the ERA is terminated, unless declared otherwise by the Company and specified in Exhibit A each Participant employed by such Affiliate will continue to participate in the ERA as an inactive Participant and will be entitled to a distribution of his entire Account or a portion thereof upon his Termination of Employment pursuant to Section 5.3.

End of Article X

ARTICLE XI
MISCELLANEOUS

11.1 No Reduction of Employer Rights. Nothing contained in this ERA will be construed as a contract of employment between the Employer and an Employee, or as a right of any Employee to continue in the Employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

11.2 Provisions Binding. All of the provisions of this ERA will be binding upon all persons who will be entitled to any benefit hereunder, their heirs and personal representatives.

End of Article XI

IN WITNESS WHEREOF , this Seventh Amended and Restated Tenet Executive Retirement Account has been executed on this 5th day of March , 2018, effective as of April 1, 2018, except as specifically provided otherwise herein.

TENET HEALTHCARE CORPORATION

By: /s/ Paul Slavin

Paul Slavin, Vice President, Total Rewards and Workforce Analytics

EXHIBIT A
GRANDFATHERED CONIFER EMPLOYEES

Section 2.1(t) of the Sixth Amended and Restated Tenet Executive Retirement Account (the " **ERA** ") provides that certain Employees of Conifer Health Solutions, LLC will continue to participate in the ERA after December 31, 2013, the date that Conifer Health Solutions, LLC ceased to be an Employer.

Name	TITLE (INCLUDES ANY SUCCESSOR TITLE)
Daniel M. Karnuta	Senior Vice President, Chief Financial Officer
Matthew C. Michaels	Senior Vice President, CHI Revenue Cycle
Megan H. North	President, VBC
Janie Patterson	Senior Vice President, Revenue Cycle Management
James M. Thatcher	Senior Vice President, Business Development
Norma A. Zeringue	Senior Vice President, Chief HR Officer

EXHIBIT B
LIMITS ON ELIGIBILITY AND PARTICIPATION

Section 3.1 of the Tenet Executive Retirement Account (the " **Prior ERA** ") provided the Retirement Plans Administration Committee, formerly the Pension Administration Committee (the " **RPAC** "), with the authority to limit the classification of employees of Tenet Healthcare Corporation or its participating affiliates (collectively the " **Employer** ") eligible to participate in the ERA and/or to limit or terminate an Eligible Person's participation in the ERA at any time and states that any such limitation will be set forth in this Exhibit B. This provision has been continued in this Sixth Amended and Restated Tenet Executive Retirement Account. This Exhibit B identifies the employees excluded from ERA participation pursuant to this provision.

Name	TITLE	Effective Date And Applicable Modification

Subsidiaries
of
Tenet Healthcare Corporation
as of December 31, 2018

Name of Entity	State or Other Jurisdiction of Formation
601 N 30th Street I, L.L.C.	Delaware
601 N 30th Street II, L.L.C.	Nebraska
601 N 30th Street III, Inc.	Nebraska
The 6300 West Roosevelt Partnership	Illinois
Abrazo Health Network EP Clinical Services, LLC	Arizona
Advantage Health Care Management Company, LLC	Delaware
Advantage Health Network, Inc.	Florida
AHM Acquisition Co., Inc.	Delaware
Alabama Cardiovascular Associates, L.L.C.	Alabama
Alabama Hand and Sports Medicine, L.L.C.	Alabama
Allegian Insurance Company	Texas
Alvarado Hospital Medical Center, Inc.	California
AMC/North Fulton Urgent Care #1, L.L.C.	Georgia
AMC/North Fulton Urgent Care #2, L.L.C.	Georgia
AMC/North Fulton Urgent Care #3, L.L.C.	Georgia
AMC/North Fulton Urgent Care #4, L.L.C.	Georgia
AMC/North Fulton Urgent Care #5, L.L.C.	Georgia
American Medical (Central), Inc.	California
AMI/HTI Tarzana Encino Joint Venture	Delaware
AMI Information Systems Group, Inc.	California
Amisub (Heights), Inc.	Delaware
Amisub (Hilton Head), Inc.	South Carolina
Amisub (North Ridge Hospital), Inc.	Florida
Amisub of California, Inc.	California
Amisub of North Carolina, Inc.	North Carolina
Amisub of South Carolina, Inc.	South Carolina
Amisub of Texas, Inc.	Delaware
Amisub (SFH), Inc.	Tennessee
Amisub (Twelve Oaks), Inc.	Delaware
Anaheim MRI Holding, Inc.	California
Arizona Care Network – Next, L.L.C.	Arizona
Arizona Health Partners, LLC	Arizona
Asia Outsourcing US, Inc.	Delaware
Atlanta Medical Center, Inc.	Georgia
Atlanta Medical Center Interventional Neurology Associates, L.L.C.	Georgia
Atlanta Medical Center Neurosurgical & Spine Specialists, L.L.C.	Georgia
Atlanta Medical Center Physician Group, L.L.C.	Georgia
Baptist Accountable Care, LLC	Texas
Baptist Diagnostics, LLC	Delaware

Baptist Health Centers, LLC	Delaware
Baptist Memorial Hospital System Physician Hospital Organization	Texas
Baptist Physician Alliance ACO, LLC	Alabama
Baptist Physician Alliance, LLC	Alabama
BBH BMC, LLC	Delaware
BBH CBMC, LLC	Delaware
BBH DevelopmentCo, LLC	Delaware
BBH NP Clinicians, Inc.	Delaware
BBH PBMC, LLC	Delaware
BBH SBMC, LLC	Delaware
BBH WBMC, LLC	Delaware
BCDC EmployeeCO, LLC	Delaware
BHC-Talladega Pediatrics, LLC	Alabama
BHS Accountable Care, LLC	Delaware
BHS Affinity, LLC	Delaware
BHS Integrated Physician Partners, LLC	Delaware
BHS Physician Performance Network, LLC	Delaware
BHS Physicians Alliance for ACE, LLC	Delaware
BHS Physicians Network, Inc.	Texas
BHS Specialty Network, Inc.	Texas
Bluffton Okatie Primary Care, L.L.C.	South Carolina
Broad River Primary Care, L.L.C.	South Carolina
Brookwood Ancillary Holdings, Inc.	Delaware
Brookwood Baptist Health 1, LLC	Delaware
Brookwood Baptist Health 2, LLC	Delaware
Brookwood Baptist Imaging, LLC	Delaware
Brookwood Center Development Corporation	Alabama
Brookwood Development, Inc.	Alabama
Brookwood Garages, L.L.C.	Alabama
Brookwood Health Services, Inc.	Alabama
Brookwood Home Health, LLC	Alabama
Brookwood - Maternal Fetal Medicine, L.L.C.	Alabama
Brookwood Occupational Health Clinic, L.L.C.	Alabama
Brookwood Parking Associates, Ltd.	Alabama
Brookwood Primary Care Cahaba Heights, L.L.C.	Alabama
Brookwood Primary Care - Homewood, L.L.C.	Alabama
Brookwood Primary Care Hoover, L.L.C.	Alabama
Brookwood Primary Care - Inverness, L.L.C.	Alabama
Brookwood Primary Care - Mountain Brook, L.L.C.	Alabama
Brookwood Primary Care - Oak Mountain, L.L.C.	Alabama
Brookwood Primary Care The Narrows, L.L.C.	Alabama
Brookwood Primary Care - Vestavia, L.L.C.	Alabama
Brookwood Primary Network Care, Inc.	Alabama
Brookwood Specialty Care - Endocrinology, L.L.C.	Alabama
Brookwood Sports and Orthopedics, L.L.C.	Alabama
Brookwood Women’s Care, L.L.C.	Alabama

BT East Dallas JV, LLP	Texas
BW Cardiology, LLC	Delaware
BW Cyberknife, LLC	Delaware
BW Hand Practice, LLC	Delaware
BW Office Buildings, LLC	Delaware
BW Parking Decks, LLC	Delaware
BW Physician Practices, LLC	Delaware
BW Retail Pharmacy, LLC	Delaware
BW Sports Practice, LLC	Delaware
C7 Technologies, LLC	Delaware
Camp Creek Urgent Care, L.L.C.	Georgia
Captive Insurance Services, Inc.	Delaware
Cardiology Physicians Associates, L.L.C.	North Carolina
Cardiology Physicians Corporation, L.L.C.	North Carolina
Cardiovascular & Thoracic Surgery Associates, L.L.C.	South Carolina
Cardiovascular Clinical Excellence at Desert Regional, LLC	California
Cardiovascular Clinical Excellence at Sierra Providence, LLC	Texas
Catawba-Piedmont Cardiothoracic Surgery, L.L.C.	South Carolina
Cedar Hill Primary Care, L.L.C.	Missouri
Center for Advanced Research Excellence, L.L.C.	Florida
Center for the Urban Child, Inc.	Pennsylvania
Central Carolina-IMA, L.L.C.	North Carolina
Central Carolina Physicians - Sandhills, L.L.C.	North Carolina
Central Valley Quality Alliance, LLC	Delaware
Central Texas Corridor Hospital Company, LLC	Delaware
CGH Hospital, Ltd.	Florida
Chalon Living, Inc.	Arizona
Children’s Hospital of Michigan Premier Network, Inc.	Michigan
CHN Holdings, LLC	Delaware
CHVI Tucson Holdings, LLC	Delaware
CML-Chicago Market Labs, Inc.	Delaware
Coast Healthcare Management, LLC	California
Coastal Carolina Medical Center, Inc.	South Carolina
Coastal Carolina Physician Practices, LLC	Delaware
Coastal Carolina Pro Fee Billing, L.L.C.	South Carolina
Commonwealth Continental Health Care, Inc.	Florida
Community Connection Health Plan, Inc.	Arizona
Community Hospital of Los Gatos, Inc.	California
Conifer Care Continuum Solutions, LLC	Maryland
Conifer Ethics and Compliance, Inc.	Delaware
Conifer Health Solutions, LLC	Delaware
Conifer Holdings, Inc.	Delaware
Conifer Patient Communications, LLC	Florida
Conifer Physician Services Holdings, Inc.	Delaware
Conifer Physician Services, Inc.	Illinois
Conifer Revenue Cycle Solutions, LLC	California

Conifer Value-Based Care, LLC	Maryland
Coral Gables Hospital, Inc.	Florida
CRNAs of Michigan	Michigan
Delray Medical Center, Inc.	Florida
Delray Medical Physician Services, L.L.C.	Florida
Desert Regional Medical Center, Inc.	California
Des Peres Hospital, Inc.	Missouri
Des Peres Physician Network, LLC	Missouri
Detroit Education & Research	Michigan
DigitalMed, Inc.	Delaware
Dignity/Abrazo Health Network, LLC	Arizona
DMC Detroit Receiving Hospital Premier Clinical Co-Management Services, LLC	Michigan
DMC Education & Research	Michigan
DMC Harper University Hospital Premier Clinical Co-Management Services, LLC	Michigan
DMC Huron Valley-Sinai Hospital Premier Clinical Management Services, LLC	Michigan
DMC Imaging, L.L.C.	Florida
Doctors Hospital of Manteca, Inc.	California
Doctors Medical Center Neurosciences Clinical Co-Management, LLC	California
Doctors Medical Center of Modesto, Inc.	California
Doctors Medical Center Orthopedics Clinical Co-Management, LLC	California
East Cobb Urgent Care, LLC	Georgia
East Cooper Coastal Family Physicians, L.L.C.	South Carolina
East Cooper Community Hospital, Inc.	South Carolina
East Cooper Hyperbarics, L.L.C.	Delaware
East Cooper OB/GYN, L.L.C.	South Carolina
East Cooper Physician Network, LLC	South Carolina
East Cooper Primary Care Physicians, L.L.C.	South Carolina
EPHC, Inc.	Texas
First Choice Physician Partners	California
FMCC Network Contracting, L.L.C.	Florida
FMC Medical, Inc.	Florida
Fort Bend Clinical Services, Inc.	Texas
Fountain Valley Regional Hospital and Medical Center	California
Fountain Valley Surgery Center, LLC	California
FREH Real Estate, L.L.C.	Florida
FRS Imaging Services, L.L.C.	Florida
FryeCare Boone, L.L.C.	North Carolina
FryeCare Morganton, L.L.C.	North Carolina
FryeCare Physicians, L.L.C.	North Carolina
FryeCare Valdese, L.L.C.	North Carolina
FryeCare Watauga, L.L.C.	North Carolina
FryeCare Women’s Services, L.L.C.	North Carolina
Frye Regional Medical Center, Inc.	North Carolina
Gardendale Surgical Associates, LLC	Alabama
Gastric Health Institute, L.L.C.	Georgia
Georgia Gifts From Grace, L.L.C.	Georgia

Georgia North Fulton Healthcare Associates, L.L.C.	Georgia
Georgia Northside Ear, Nose and Throat, L.L.C.	Georgia
Georgia Physicians of Cardiology, L.L.C.	Georgia
Georgia Spectrum Neurosurgical Specialists, L.L.C.	Georgia
Good Samaritan Cardiac & Vascular Management, LLC	Florida
Good Samaritan Medical Center, Inc.	Florida
Good Samaritan Surgery, L.L.C.	Florida
Graystone Family Healthcare - Tenet North Carolina, L.L.C.	North Carolina
Greater Dallas Healthcare Enterprises	Texas
Greater Northwest Houston Enterprises	Texas
Greystone Internal Medicine - Brookwood, L.L.C.	Alabama
Gulf Coast Community Hospital, Inc.	Mississippi
Hardeeville Medical Group, L.L.C.	South Carolina
Hardeeville Primary Care, L.L.C.	South Carolina
Harlingen Physician Network, Inc.	Texas
Harper-Hutzel AHP Services, Inc.	Michigan
HCH Tucson Holdings, LLC	Delaware
HCN Emerus Management Sub, LLC	Texas
HCN Emerus Texas, LLC	Texas
HCN Laboratories, Inc.	Texas
HCN Physicians, Inc.	Texas
HCN Surgery Center Holdings, Inc.	Delaware
HDMC Holdings, L.L.C.	Delaware
Health & Wellness Surgery Center, L.P.	California
Healthcare Compliance, LLC	District of Columbia
The Healthcare Insurance Corporation	Cayman Islands
Healthcare Network Alabama, Inc.	Delaware
Healthcare Network CFMC, Inc.	Delaware
Healthcare Network Georgia, Inc.	Delaware
Healthcare Network Holdings, Inc.	Delaware
Healthcare Network Hospitals (Dallas), Inc.	Delaware
Healthcare Network Hospitals, Inc.	Delaware
Healthcare Network Louisiana, Inc.	Delaware
Healthcare Network Missouri, Inc.	Delaware
Healthcare Network North Carolina, Inc.	Delaware
Healthcare Network South Carolina, Inc.	Delaware
Healthcare Network Tennessee, Inc.	Delaware
Healthcare Network Texas, Inc.	Delaware
The Healthcare Underwriting Company, a Risk Retention Group	Vermont
HealthCorp Network, Inc.	Delaware
Healthpoint of North Carolina, L.L.C.	North Carolina
Health Services CFMC, Inc.	Texas
Health Services HNMC, Inc.	Delaware
Health Services Network Care, Inc.	Delaware
Health Services Network Hospitals, Inc.	Delaware
Health Services Network Texas, Inc.	Delaware

Heart and Vascular Institute of Michigan	Michigan
Hialeah Hospital, Inc.	Florida
Hialeah Real Properties, Inc.	Florida
Hickory Family Practice Associates - Tenet North Carolina, L.L.C.	North Carolina
Hilton Head Health System, L.P.	South Carolina
Hilton Head Regional Healthcare, L.L.C.	South Carolina
Hilton Head Regional OB/GYN Partners, L.L.C.	South Carolina
Hilton Head Regional Physician Network – Georgia, L.L.C.	Georgia
Hilton Head Regional Physician Network, LLC	South Carolina
Hitchcock State Street Real Estate, Inc.	California
HNMC, Inc.	Delaware
HNW GP, Inc.	Delaware
HNW LP, Inc.	Delaware
Holy Cross Hospital, Inc.	Arizona
Home Health Partners of San Antonio, LLC	Texas
Hoover Doctors Group, Inc.	Alabama
Hoover Land, LLC	Delaware
Hospital Development of West Phoenix, Inc.	Delaware
Hospital RCM Services, LLC	Texas
Hospital Underwriting Group, Inc.	Tennessee
Houston Northwest Partners, Ltd.	Texas
Houston Specialty Hospital, Inc.	Texas
Houston Sunrise Investors, Inc.	Delaware
HSRM International, Inc.	California
HUG Services, Inc.	Delaware
The Huron Corporation	District of Columbia
Imaging Center at Baxter Village, L.L.C.	South Carolina
InforMed Insurance Services, LLC	Maryland
International Health and Wellness, Inc.	Florida
JFK Memorial Hospital, Inc.	California
Journey Home Healthcare of San Antonio, LLC	Texas
Laguna Medical Systems, Inc.	California
Lake Health Care Facilities Inc.	Delaware
LakeFront Medical Associates, LLC	Delaware
Lakewood Regional Medical Center, Inc.	California
Lifemark Hospitals, Inc.	Delaware
Lifemark Hospitals of Florida, Inc.	Florida
Lifemark Hospitals of Louisiana, Inc.	Louisiana
Los Alamitos Medical Center, Inc.	California
MacNeal Management Services, Inc.	Illinois
MacNeal Medical Records, Inc.	Delaware
MacNeal Physicians Group, LLC	Delaware
Meadowcrest Hospital, LLC	Louisiana
Medplex Outpatient Medical Centers, Inc.	Alabama
Memphis Urgent Care #1, L.L.C.	Tennessee
Memphis Urgent Care #2, L.L.C.	Tennessee

MetroWest Accountable Health Care Organization, LLC	Massachusetts
MetroWest HomeCare & Hospice, LLC	Massachusetts
Michigan Pioneer ACO, LLC	Delaware
Michigan Regional Imaging, LLC	Michigan
Midwest Pharmacies, Inc.	Illinois
Mobile Imaging Management, LLC	Michigan
Mobile Technology Management, LLC	Michigan
Nacogdoches ASC-LP, Inc.	Delaware
National Ancillary, Inc.	Texas
National ASC, Inc.	Delaware
National Diagnostic Imaging Centers, Inc.	Texas
National HHC, Inc.	Texas
National Home Health Holdings, Inc.	Delaware
National ICN, Inc.	Texas
National Medical Services II, Inc.	Florida
National Outpatient Services Holdings, Inc.	Delaware
National Urgent Care Holdings, Inc.	Delaware
National Urgent Care, Inc.	Florida
Network Management Associates, Inc.	California
New Dimensions, LLC	Illinois
New England Physician Performance Network, LLC	Delaware
New H Acute, Inc.	Delaware
New Medical Horizons II, Ltd.	Texas
NMC Lessor, L.P.	Texas
NME Headquarters, Inc.	California
N.M.E. International (Cayman) Limited	Cayman Islands
NME Properties Corp.	Tennessee
NME Properties, Inc.	Delaware
NME Property Holding Co., Inc.	Delaware
NME Psychiatric Hospitals, Inc.	Delaware
NME Rehabilitation Properties, Inc.	Delaware
North Carolina Community Family Medicine, L.L.C.	North Carolina
North Fulton Cardiovascular Medicine, L.L.C.	Georgia
North Fulton Hospitalist Group, L.L.C.	Georgia
North Fulton Medical Center, Inc.	Georgia
North Fulton Primary Care Associates, L.L.C.	Georgia
North Fulton Primary Care - Willeo Rd., L.L.C.	Delaware
North Fulton Primary Care - Windward Parkway, L.L.C.	Georgia
North Fulton Primary Care - Wylie Bridge, L.L.C.	Georgia
North Fulton Pulmonary Specialists, L.L.C.	Georgia
North Fulton Women’s Consultants, L.L.C.	Georgia
North Miami Medical Center, Ltd.	Florida
North Shore Medical Billing Center, L.L.C.	Florida
North Shore Medical Center, Inc.	Florida
North Shore Physician Practices, L.L.C.	Florida
NUCH of Connecticut, LLC	Connecticut

NUCH of Georgia, L.L.C.	Georgia
NUCH of Massachusetts, LLC	Massachusetts
NUCH of Michigan, Inc.	Michigan
NUCH of Texas	Texas
Okatie Surgical Partners, L.L.C.	South Carolina
Olive Branch Urgent Care #1, LLC	Mississippi
OrNda Hospital Corporation	California
Orthopedic Associates of the Lowcountry, L.L.C.	South Carolina
Palm Beach Gardens Cardiac and Vascular Partners, LLC	Florida
Palm Beach Gardens Community Hospital, Inc.	Florida
Palm Valley Medical Center Campus Association	Arizona
Park Plaza Hospital Billing Center, L.L.C.	Texas
PDN, L.L.C.	Texas
Phoenix Health Plans, Inc.	Arizona
PHPS-CHM Acquisition, Inc.	Delaware
Physician Performance Network, L.L.C.	Delaware
Physician Performance Network of Arizona, LLC	Delaware
Physician Performance Network of Detroit	Michigan
Physician Performance Network of South Carolina, LLC	Delaware
Physician Performance Network of Tucson, LLC	Arizona
Physicians Performance Network of Houston	Texas
Physicians Performance Network of North Texas	Texas
Piedmont Behavioral Medicine Associates, LLC	South Carolina
Piedmont Cardiovascular Physicians, L.L.C.	South Carolina
Piedmont Carolina OB/GYN of York County, L.L.C.	South Carolina
Piedmont Carolina Vascular Surgery, L.L.C.	South Carolina
Piedmont/Carolinas Radiation Therapy, LLC	South Carolina
Piedmont East Urgent Care Center, L.L.C.	South Carolina
Piedmont Express Care at Sutton Road, L.L.C.	South Carolina
Piedmont Family Practice at Baxter Village, L.L.C.	South Carolina
Piedmont Family Practice at Rock Hill, L.L.C.	South Carolina
Piedmont Family Practice at Tega Cay, L.L.C.	South Carolina
Piedmont General Surgery Associates, L.L.C.	South Carolina
Piedmont Internal Medicine at Baxter Village, L.L.C.	South Carolina
Piedmont Medical Center Cardiovascular Clinical Co-Management, L.L.C	South Carolina
Piedmont Physician Network, LLC	South Carolina
Piedmont Pulmonology, L.L.C.	South Carolina
Piedmont Surgical Specialists, L.L.C.	South Carolina
Piedmont Urgent Care and Industrial Health Centers, Inc.	South Carolina
Piedmont Urgent Care Center at Baxter Village, L.L.C.	South Carolina
Placentia-Linda Hospital, Inc.	California
PMC Physician Network, L.L.C.	South Carolina
PM CyFair Land Partners, LLC	Delaware
Practice Partners Management, L.P.	Texas
Premier ACO Physicians Network, LLC	California
Premier Health Plan Services, Inc.	California

Premier Medical Specialists, L.L.C.	Missouri
Professional Liability Insurance Company	Tennessee
Pros Temporary Staffing, Inc.	Illinois
PSS Patient Solution Services, LLC	Texas
Republic Health Corporation of Rockwall County	Nevada
Resolute Health Physicians Network, Inc.	Texas
Resolute Hospital Company, LLC	Delaware
RHC Parkway, Inc.	Delaware
Rheumatology Associates of Atlanta Medical Center, L.L.C.	Georgia
R.H.S.C. El Paso, Inc.	Texas
Rio Grande Valley Indigent Health Care Corporation	Texas
RLC, LLC	Arizona
Rock Bridge Surgical Institute, L.L.C.	Georgia
Saint Francis-Arkansas Physician Network, LLC	Arkansas
Saint Francis-Bartlett Physician Network, LLC	Tennessee
Saint Francis Behavioral Health Associates, L.L.C.	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 Inpatient Physicians, 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 Medical Specialists, L.L.C.	Tennessee
Saint Francis Physician Network, LLC	Tennessee
Saint Francis Quality Alliance, LLC	Delaware
Saint Francis Surgical Associates, L.L.C.	Tennessee
Saint Vincent Physician Services, Inc.	Massachusetts
San Ramon Ambulatory Care, LLC	Delaware
San Ramon ASC, L. P.	California
San Ramon Regional Medical Center, LLC	Delaware
San Ramon Surgery Center, L.L.C.	California
SFMP, Inc.	Tennessee
SFMPE - Crittenden, L.L.C.	Arkansas
Shelby Baptist Affinity, LLC	Alabama
Shelby Baptist Ambulatory Surgery Center, LLC	Alabama
Sierra Providence Healthcare Enterprises	Texas
Sierra Providence Health Network, Inc.	Texas
Sierra Vista Hospital, Inc.	California
Sinai-Grace Premier Clinical Management Services LLC	Michigan
SL-HLC, Inc.	Missouri
SLH Physicians, L.L.C.	Missouri
SLH Vista, Inc.	Missouri

SLUH Anesthesia Physicians, L.L.C.	Missouri
SMSJ Tucson Holdings, LLC	Delaware
South Carolina East Cooper Surgical Specialists, L.L.C.	South Carolina
South Carolina Health Services, Inc.	South Carolina
South Carolina SeWee Family Medicine, L.L.C.	South Carolina
South Fulton Health Care Centers, Inc.	Delaware
SouthCare Physicians Group Neurology, L.L.C.	Georgia
SouthCare Physicians Group Obstetrics & Gynecology, L.L.C.	Georgia
Southeast Michigan Physicians' Insurance Company	Michigan
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. Chris Onsite Pediatric Partners, L.L.C	Pennsylvania
St. Christopher's Pediatric Urgent Care Center - Allentown, L.L.C	Pennsylvania
St. Joseph's Hospital Surgical Co-Management, LLC	Arizona
St. Mary's Hospital Cardiovascular Co-Management LLC	Arizona
St. Mary's Hospital Surgical Co-Management LLC	Arizona
St. Mary's Levee Company, LLC	Arizona
St. Mary's Medical Center, Inc.	Florida
Sunrise Medical Group I, L.L.C.	Florida
Sunrise Medical Group II, L.L.C.	Florida
Sunrise Medical Group IV, L.L.C.	Florida
Surgical & Bariatric Associates of Atlanta Medical Center, L.L.C.	Georgia
Surgical Clinical Excellence at Desert Regional, LLC	California
Sutton Road Pediatrics, L.L.C.	South Carolina
Sylvan Grove Hospital, Inc.	Georgia
Syndicated Office Systems, LLC	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 HealthSystem Bucks County, L.L.C.	Pennsylvania

Tenet HealthSystem Graduate, L.L.C.	Pennsylvania
Tenet HealthSystem Hahnemann, L.L.C.	Pennsylvania
Tenet HealthSystem Medical, Inc.	Delaware
Tenet HealthSystem Nacogdoches ASC GP, Inc.	Texas
Tenet HealthSystem Philadelphia, Inc.	Pennsylvania
Tenet HealthSystem Roxborough, LLC	Pennsylvania
Tenet HealthSystem St. Christopher's Hospital for Children, L.L.C.	Pennsylvania
Tenet Hilton Head Heart, L.L.C.	South Carolina
Tenet Hospitals Limited	Texas
Tenet Network Management, Inc.	Florida
Tenet Patient Safety Organization, LLC	Texas
Tenet Physician Resources, LLC	Delaware
Tenet Physician Services - Hilton Head, Inc.	South Carolina
Tenet Rehab Piedmont, Inc.	South Carolina
Tenet Relocation Services, L.L.C.	Texas
Tenet SC East Cooper Hospitalists, L.L.C.	South Carolina
Tenet South Carolina Gastrointestinal Surgical Specialists, L.L.C.	South Carolina
Tenet South Carolina Island Medical, L.L.C.	South Carolina
Tenet South Carolina Lowcountry OB/GYN, L.L.C.	South Carolina
Tenet South Carolina Mt. Pleasant OB/GYN, L.L.C.	South Carolina
Tenet Unifour Urgent Care Center, L.L.C.	North Carolina
Tenet Ventures, Inc.	Delaware
TFPS IV, L.L.C.	Florida
TH Healthcare, Ltd.	Texas
TPR Practice Management, LLC	Delaware
TPS VI of PA, L.L.C.	Pennsylvania
Tucson Hospital Holdings, Inc.	Delaware
Tucson Physician Group Holdings, LLC	Delaware
Turlock Land Company, LLC	California
Twin Cities Community Hospital, Inc.	California
Universal Medical Care Center, L.L.C.	Florida
Urgent Care Centers of Arizona, LLC	Arizona
USPI Holding Company, Inc.	Delaware
USVI Health and Wellness, Inc.	St. Croix
Valley Baptist Lab Services, LLC	Texas
Valley Baptist Physician Performance Network	Texas
Valley Baptist Realty Company, LLC	Delaware
Valley Baptist Wellness Center, LLC	Texas
Valley Health Care Network	Texas
Vanguard Health Financial Company, LLC	Delaware
Vanguard Health Holding Company I, LLC	Delaware
Vanguard Health Holding Company II, LLC	Delaware
Vanguard Health Management, Inc.	Delaware
Vanguard Health Systems, Inc.	Delaware
Vanguard Holding Company I, Inc.	Delaware
Vanguard Holding Company II, Inc.	Delaware

Vanguard Medical Specialists, LLC	Delaware
Vanguard Physician Services, LLC	Delaware
VB Brownsville IMP ASC, LLC	Texas
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 2, 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 10, Inc.	Delaware
VHS Acquisition Subsidiary Number 11, Inc.	Delaware
VHS Acquisition Subsidiary Number 12, Inc.	Delaware
VHS Arizona Heart Institute, Inc.	Delaware
VHS Brownsville Hospital Company, LLC	Delaware
VHS Chicago Market Procurement, LLC	Delaware
VHS Children's Hospital of Michigan, Inc.	Delaware
VHS Detroit Businesses, Inc.	Delaware
VHS Detroit Receiving Hospital, Inc.	Delaware
VHS Detroit Ventures, Inc.	Delaware
VHS Harlingen Hospital Company, LLC	Delaware
VHS Harper-Hutzel Hospital, Inc.	Delaware
VHS Holding Company, Inc.	Delaware
VHS Huron Valley-Sinai Hospital, Inc.	Delaware
VHS Imaging Centers, Inc.	Delaware
VHS New England Holding Company I, Inc.	Delaware
VHS of Anaheim, Inc.	Delaware
VHS of Arrowhead, Inc.	Delaware
VHS of Huntington Beach, Inc.	Delaware
VHS of Illinois, Inc.	Delaware
VHS of Michigan, Inc.	Delaware
VHS of Michigan Staffing, Inc.	Delaware
VHS of Orange County, Inc.	Delaware
VHS of Phoenix, Inc.	Delaware
VHS of South Phoenix, Inc.	Delaware
VHS Outpatient Clinics, Inc.	Delaware
VHS Phoenix Health Plan, Inc.	Delaware
VHS Physicians of Michigan	Michigan

VHS Rehabilitation Institute of Michigan, Inc.	Delaware
VHS San Antonio Partners, LLC	Delaware
VHS Sinai-Grace Hospital, Inc.	Delaware
VHS University Laboratories, Inc.	Delaware
VHS Valley Health System, LLC	Delaware
VHS Valley Holdings, LLC	Delaware
VHS Valley Management Company, Inc.	Delaware
VHS West Suburban Medical Center, Inc.	Delaware
VHS Westlake Hospital, Inc.	Delaware
V-II Acquisition Co., Inc.	Pennsylvania
Walker Baptist Affinity, LLC	Alabama
Watermark Physician Services, Inc.	Illinois
West Boca Health Services, L.L.C.	Florida
West Boca Medical Center, Inc.	Florida
West Boynton Urgent Care, L.L.C.	Florida
West Palm Healthcare Real Estate, Inc.	Florida
West Suburban Radiation Therapy Center, LLC	Delaware
Wilshire Rental Corp.	Delaware

Subsidiaries of USPI Holding Company, Inc.

Name of Entity	**State or Other Jurisdiction of Formation**
25 East Same Day Surgery, L.L.C.	Illinois
300 PBL Development, LLC	Delaware
45th Street MOB, LLC	Florida
Advanced Ambulatory Surgical Care, L.P.	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 Winter Garden, LLC	Florida
Adventist Midwest Health/USP Surgery Centers, L.L.C.	Illinois
AIG Holdings, LLC	Texas
AIGB Global, LLC	Texas
AIGB Group, Inc.	Delaware
AIGB Holdings, Inc.	Delaware
AIGB Management Services, LLC	Texas
Alabama Digestive Health Endoscopy Center, L.L.C.	Alabama
Alamo Heights Surgicare, L.P.	Texas
Alliance Surgery Birmingham, LLC	Delaware
Alliance Surgery, Inc.	Delaware
All Star MOB, LLC	Texas
Ambulatory Surgical Associates, LLC	Tennessee

Ambulatory Surgical Center of Somerville, LLC	New Jersey
The Ambulatory Surgical Center of St. Louis, L.P.	Missouri
American Institute of Gastric Banding Phoenix, Limited Partnership	Arizona
American Institute of Gastric Banding, Ltd.	Texas
Anaheim Hills Medical Imaging, L.L.C.	California
Anesthesia Partners of Gallatin, LLC	Tennessee
APN	Texas
ARC Worcester Center L.P.	Tennessee
Arlington Orthopedic and Spine Hospital, LLC	Texas
Arrowhead Endoscopy and Pain Management Center, LLC	Delaware
ASC Coalition, Inc.	Delaware
ASJH Joint Venture, LLC	Arizona
Atlantic Health-USP Surgery Centers, L.L.C.	New Jersey
Avita/USP Surgery Centers, L.L.C.	Ohio
Bagley Holdings, LLC	Ohio
Baptist Plaza Surgicare, L.P.	Tennessee
Baptist Surgery Center, L.P.	Tennessee
Baptist Women's Health Center, LLC	Tennessee
Baptist/USP Surgery Centers, L.L.C.	Texas
Bartlett ASC, LLC	Tennessee
Baylor Surgicare at Baylor Plano, LLC	Texas
Baylor Surgicare at Blue Star, LLC	Texas
Baylor Surgicare at Ennis, LLC	Texas
Baylor Surgicare at Granbury, LLC	Texas
Baylor Surgicare at Mansfield, LLC	Texas
Baylor Surgicare at North Dallas, LLC	Texas
Baylor Surgicare at Plano Parkway, LLC	Texas
Baylor Surgicare at Plano, LLC	Texas
Beaumont Surgical Affiliates, Ltd.	Texas
Bellaire Outpatient Surgery Center, L.L.P.	Texas
Berkshire Eye, LLC	Pennsylvania
Bloomington ASC, LLC	Indiana
Blue Ridge/USP Surgery Centers, LLC	Tennessee
Bluffton Okatie Surgery Center, L.L.C.	South Carolina
Bon Secours Surgery Center at Harbour View, LLC	Virginia
Bon Secours Surgery Center at Virginia Beach, LLC	Virginia
Bozeman Health/USP Surgery Centers, L.L.C.	Montana
Briarcliff Ambulatory Surgery Center, L.P.	Missouri
Brookwood Baptist Health 3, LLC	Delaware
Brookwood Diagnostic Imaging Center, LLC	Delaware
Brookwood Women's Diagnostic Center, LLC	Delaware
California Joint & Spine, LLC	California
Camp Lowell Surgery Center, L.L.C.	Arizona
CareSpot of Austin, LLC	Delaware
CareSpot of Memphis, LLC	Delaware
CareSpot of Orlando/HSI Urgent Care, LLC	Delaware

Carondelet St. Mary's-Northwest, L.L.C.	Arizona
Cascade Spine Center, LLC	Delaware
Castle Rock Surgery Center, LLC	Colorado
Cedar Park Surgery Center, L.L.P.	Texas
Centennial ASC, LLC	Texas
The Center for Ambulatory Surgical Treatment, L.P.	California
Central Jersey Surgery Center, LLC	Georgia
Central Virginia Surgi-Center, L.P.	Virginia
Centura Ventures Surgery Centers, LLC	Colorado
Chandler Endoscopy Ambulatory Surgery Center, LLC	Arizona
Charlotte Endoscopic Surgery Center, LLC	Florida
Chattanooga Pain Management Center, LLC	Delaware
Chesterfield Ambulatory Surgery Center, L.P.	Missouri
Chesterfield Anesthesia Associates of Missouri, LLC	Missouri
CHIC/USP Surgery Centers, LLC	Colorado
Chico Surgery Center, L.P.	California
CHRISTUS Cabrini Surgery Center, L.L.C.	Louisiana
Clarkston ASC Partners, LLC	Michigan
Clarksville Surgery Center, LLC	Tennessee
Coastal Endo LLC	New Jersey
Coast Surgery Center, L.P.	California
Colorado GI Centers, LLC	Colorado
Community Hospital, LLC	Oklahoma
Conroe Surgery Center 2, LLC	Texas
Coral Ridge Outpatient Center, LLC	Florida
Corpus Christi Surgicare, Ltd.	Texas
Covenant/USP Surgery Centers, LLC	Tennessee
Creekwood Investors, LLC	Missouri
Creekwood Surgery Center, L.P.	Missouri
Crown Point Surgery Center, LLC	Colorado
CS/USP General Partner, LLC	Texas
CS/USP Surgery Centers, LP	Texas
Dallas Surgical Partners, LLC	Texas
Denton Surgicare Partners, Ltd.	Texas
Denton Surgicare Real Estate, Ltd.	Texas
Denville Surgery Center, LLC	New Jersey
Desert Cove MOB, LLC	Arizona
Desert Ridge Outpatient Surgery, LLC	Arizona
Desoto Surgicare Partners, Ltd.	Texas
Destin Surgery Center, LLC	Florida
DH/USP Sacramento Pain GP, LLC	California
DH/USP SJOSC Investment Company, L.L.C.	Arizona
Dignity/USP Folsom GP, LLC	California
Dignity/USP Grass Valley GP, LLC	California
Dignity/USP Las Vegas Surgery Centers, LLC	Nevada
Dignity/USP Metro Surgery Center, LLC	Arizona

Dignity/USP/John Muir East Bay Surgery Centers, LLC	California
Dignity/USP NorCal Surgery Centers, LLC	California
Dignity/USP Phoenix Surgery Centers II, LLC	Arizona
Dignity/USP Phoenix Surgery Centers, LLC	Arizona
Dignity/USP Redding GP, LLC	California
Dignity/USP Roseville GP, LLC	California
Doctors Outpatient Surgery Center of Jupiter, L.L.C.	Florida
East Atlanta Endoscopy Centers, LLC	Georgia
East Portland Surgery Center, LLC	Oregon
East West Surgery Center, L.P.	Georgia
Eastgate Building Center, L.L.C.	Ohio
Effingham Surgical Partners, LLC	Illinois
Einstein Montgomery Surgery Center, LLC	Pennsylvania
Einstein/USP Surgery Centers, L.L.C.	Pennsylvania
El Mirador Surgery Center, L.L.C.	California
El Paso Center for Gastrointestinal Endoscopy, LLC	Texas
El Paso Day Surgery, LLC	Texas
Emerson Surgery Center, LLC	Missouri
Encinitas Endoscopy Center, LLC	California
Endoscopy Center of Hackensack, LLC	New Jersey
Endoscopy Center of South Sacramento, LLC	California
Endoscopy Consultants, LLC	Georgia
EPIC ASC, LLC	Kansas
Eye Center of Nashville UAP, LLC	Tennessee
Eye Surgery Center of Nashville, LLC	Tennessee
Flatirons Surgery Center, LLC	Colorado
Folsom Outpatient Surgery Center, L.P.	California
Fort Worth Hospital Real Estate, LP	Texas
Fort Worth Surgicare Partners, Ltd.	Texas
FPN – Frisco Physicians Network	Texas
Franklin Endo UAP, LLC	Tennessee
Franklin Endoscopy Center, LLC	Tennessee
Frisco Medical Center, L.L.P.	Texas
Frontenac Ambulatory Surgery & Spine Care Center, L.P.	Missouri
Gamma Surgery Center, LLC	Delaware
Garland Surgicare Partners, Ltd.	Texas
GCSA Ambulatory Surgery Center, LLC	Texas
Genesis ASC Partners, LLC	Michigan
Georgia Endoscopy Center, LLC	Georgia
Georgia Musculoskeletal Network, Inc.	Georgia
Georgia Spine Surgery Center, LLC	Delaware
Golden Ridge ASC, LLC	Colorado
Grapevine Surgicare Partners, Ltd.	Texas
Grass Valley Outpatient Surgery Center, L.P.	California
Greenville Physicians Surgery Center, LLP	Texas
Greenwood ASC, LLC	Delaware

Hacienda Outpatient Surgery Center, LLC	California
Harvard Park Surgery Center, LLC	Colorado
Hazelwood Endoscopy Center, LLC	Missouri
HCN Sunnyvale Holdings LLC	Delaware
HCN Surgery Center Holdings, Inc.	Delaware
Healthcare Partners Investments, LLC	Delaware
Health Horizons of Kansas City, Inc.	Tennessee
Health Horizons of Murfreesboro, Inc.	Tennessee
Health Horizons/Piedmont Joint Venture, LLC	Tennessee
Healthmark Partners, Inc.	Delaware
Heritage Park Surgical Hospital, LLC	Texas
Hershey Outpatient Surgery Center, L.P.	Pennsylvania
Hill Country ASC Partners, LLC	Texas
Hill Country Surgery Center, LLC	Texas
Hinsdale Surgical Center, LLC	Illinois
HMA/Solantic Joint Venture, LLC	Delaware
HMHP/USP Surgery Centers, LLC	Ohio
HMH-USP Surgery Centers, LLC	New Jersey
Houston PSC, L.P.	Texas
HPI Holdings, LLC	Oklahoma
HPI North, LLC	Oklahoma
HPI Physicians, LLC	Oklahoma
HSS Palm Beach Ambulatory Surgery Center, LLC	Florida
HSS/USP Surgery Center, LLC	Florida
HUMC/USP Surgery Centers, LLC	New Jersey
Hyde Park Surgery Center, LLC	Texas
ICNU Rockford, LLC	Illinois
Integris/USP Health Ventures, LLC	Oklahoma
Irving-Coppell Surgical Hospital, L.L.P.	Texas
Jackson Surgical Center, LLC	New Jersey
Jacksonville Endoscopy Centers, LLC	Florida
JFP UAP Sugarland, LLC	Texas
KHS Ambulatory Surgery Center LLC	New Jersey
KHS/USP Surgery Centers, LLC	New Jersey
Lake Endoscopy Center, LLC	Florida
Lake Lansing ASC Partners, LLC	Michigan
Lake Surgical Hospital Slidell, LLC	Louisiana
Lakewood Surgery Center, LLC	Delaware
Lansing ASC Partners, LLC	Michigan
Lawrenceville Surgery Center, L.L.C.	Georgia
Lebanon Endoscopy Center, LLC	Tennessee
Legacy Warren Partners, L.P.	Texas
Legacy/USP Surgery Centers, L.L.C.	Oregon
Lewisville Surgicare Partners, Ltd.	Texas
Liberty Ambulatory Surgery Center, L.P.	Missouri
Lone Star Endoscopy Center, LLC	Texas

Lubbock ASC Holding Co, LLC	Texas
Magnetic Resonance Imaging of San Luis Obispo, Inc.	California
Magnolia Surgery Center Limited Partnership	Delaware
Manchester Ambulatory Surgery Center, LP	Missouri
Mary Immaculate Ambulatory Surgery Center, LLC	Virginia
MASC Partners, LLC	Missouri
Mason Ridge Ambulatory Surgery Center, L.P.	Missouri
Mayfield Spine Surgery Center, LLC	Ohio
McLaren ASC of Flint, LLC	Michigan
MCSH Real Estate Investors, Ltd.	Texas
Medical House Staffing, LLC	Texas
Medical Park Tower Surgery Center, LLC	Texas
Medplex Outpatient Surgery Center, Ltd.	Alabama
Memorial Hermann Bay Area Endoscopy Center, LLC	Texas
Memorial Hermann Endoscopy & Surgery Center North Houston, L.L.C.	Texas
Memorial Hermann Endoscopy Center North Freeway, LLC	Texas
Memorial Hermann Specialty Hospital Kingwood, L.L.C.	Texas
Memorial Hermann Sugar Land Surgical Hospital, L.L.P.	Texas
Memorial Hermann Surgery Center Brazoria, LLC	Texas
Memorial Hermann Surgery Center Katy, LLP	Texas
Memorial Hermann Surgery Center Kingsland, L.L.C.	Texas
Memorial Hermann Surgery Center Kirby, LLC	Texas
Memorial Hermann Surgery Center Memorial City, L.L.C.	Texas
Memorial Hermann Surgery Center Northwest LLP	Texas
Memorial Hermann Surgery Center Pinecroft, LLC	Texas
Memorial Hermann Surgery Center Preston Road, Ltd.	Texas
Memorial Hermann Surgery Center Richmond, LLC	Texas
Memorial Hermann Surgery Center Southwest, L.L.P.	Texas
Memorial Hermann Surgery Center Sugar Land, LLP	Texas
Memorial Hermann Surgery Center Texas Medical Center, LLP	Texas
Memorial Hermann Surgery Center – The Woodlands, LLP	Texas
Memorial Hermann Surgery Center Woodlands Parkway, LLC	Texas
Memorial Hermann Texas International Endoscopy Center, LLC	Texas
Memorial Hermann/USP Surgery Centers II, L.P.	Texas
Memorial Hermann/USP Surgery Centers III, LLP	Texas
Memorial Hermann/USP Surgery Centers IV, LLP	Texas
Memorial Hermann West Houston Surgery Center, LLC	Texas
Memorial Surgery Center, LLC	Oklahoma
Merced Ambulatory Surgery Center, LLC	California
Mercy/USP Health Ventures, L.L.C.	Iowa
Metro Surgery Center, LLC	Delaware
Metrocrest Surgery Center, L.P.	Texas
Metroplex Surgicare Partners, Ltd.	Texas
Metropolitan New Jersey, LLC	New Jersey
MH Memorial City Surgery, LLC	Texas
MH/USP Bay Area, LLC	Texas

MH/USP Brazoria, LLC	Texas
MH/USP Kingsland, LLC	Texas
MH/USP Kingwood, LLC	Texas
MH/USP Kirby, LLC	Texas
MH/USP North Freeway, LLC	Texas
MH/USP North Houston, LLC	Texas
MH/USP Richmond, LLC	Texas
MH/USP Sugar Land, LLC	Texas
MH/USP TMC Endoscopy, LLC	Texas
MH/USP West Houston, L.L.C.	Texas
MH/USP Woodlands Parkway, LLC	Texas
Michigan ASC Partners, L.L.C.	Michigan
Mid Rivers Ambulatory Surgery Center, L.P.	Missouri
Mid State 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
Mid-State Endoscopy Center, LLC	Tennessee
Mid-TSC Development, LP	Texas
Midwest Digestive Health Center, LLC	Missouri
Millennium Surgical Center, LLC	New Jersey
Modesto Radiology Imaging, Inc.	California
Mountain Empire Surgery Center, L.P.	Georgia
MSH Partners, LLC	Texas
MSV Health/USP Surgery Centers, LLC	South Carolina
Murdock Ambulatory Surgery Center, LLC	Florida
National Imaging Center Holdings, Inc.	Delaware
National Surgery Center Holdings, Inc.	Delaware
New Horizons Surgery Center, LLC	Ohio
New Mexico Orthopaedic Surgery Center, L.P.	Georgia
Newhope Imaging Center, Inc.	California
NHSC Holdings, LLC	Ohio
NICH GP Holdings, LLC	Delaware
NKCH/USP Briarcliff GP, LLC	Missouri
NKCH/USP Liberty GP, LLC	Missouri
NKCH/USP Surgery Centers II, L.L.C.	Missouri
NKCH/USP Surgery Centers, LLC	Missouri
NMC Surgery Center, L.P.	Texas
North Anaheim Surgery Center, LLC	California
North Campus Surgery Center, LLC	Missouri
North Central Surgical Center, L.L.P.	Texas
North Garland Surgery Center, L.L.P.	Texas
North Haven Surgery Center, LLC	Connecticut
North Shore Same Day Surgery, L.L.C.	Illinois
North State Surgery Centers, L.P.	California
Northern Monmouth Regional Surgery Center, L.L.C.	New Jersey

Northridge Surgery Center, L.P.	Tennessee
NorthShore/USP Surgery Centers II, L.L.C.	Illinois
Northwest Ambulatory Surgery Center, LLC	Oregon
Northwest Georgia Orthopaedic Surgery Center, LLC	Georgia
Northwest Regional ASC, LLC	Delaware
Northwest Surgery Center, LLP	Texas
Northwest Surgery Center, Ltd.	Texas
Novant Health/USP Surgery Centers, LLC	North Carolina
Novant/UVA/USP Surgery Centers, LLC	Virginia
NSCH GP Holdings, LLC	Delaware
NSCH/USP Desert Surgery Centers, L.L.C.	Delaware
OCOMS Imaging, LLC	Oklahoma
OCOMS Professional Services, LLC	Oklahoma
Oklahoma Center for Orthopedic and Multi-Specialty Surgery, LLC	Oklahoma
Old Tesson Surgery Center, L.P.	Missouri
Olive Ambulatory Surgery Center, LLC	Missouri
OLOL Pontchartrain Surgery Center, LLC	Louisiana
OLOL/USP Surgery Centers, L.L.C.	Texas
Ophthalmology Anesthesia Services, LLC	Florida
Ophthalmology Surgery Center of Orlando, LLC	Florida
Optimum Spine Center, LLC	Georgia
Orlando Health/USP Surgery Centers, L.L.C.	Florida
OrthoArizona Surgery Center Gilbert, LLC	Arizona
OrthoLink ASC Corporation	Tennessee
OrthoLink Physicians Corporation	Delaware
OrthoLink Radiology Services Corporation	Tennessee
OrthoLink/ Georgia ASC, Inc.	Georgia
OrthoLink/Baptist ASC, LLC	Tennessee
OrthoLink/New Mexico ASC, Inc.	Georgia
Orthopedic and Surgical Specialty Company, LLC	Arizona
Orthopedic South Surgical Partners, LLC	Georgia
The Outpatient Center, LLC	Florida
Pacific Endoscopy and Surgery Center, LLC	California
Pacific Endo-Surgical Center, L.P.	California
PAHS/USP Surgery Centers, LLC	Colorado
Pain Diagnostic and Treatment Center, L.P.	California
Palm Beach International Surgery Center, LLC	Florida
Paramus Endoscopy, LLC	New Jersey
Park Cities Surgery Center, LLC	Texas
Parkway Recovery Care Center, LLC	Nevada
Parkway Surgery Center, LLC	Nevada
Parkwest Surgery Center, L.P.	Tennessee
Patient Partners, LLC	Tennessee
Pediatric Surgery Center – Odessa, LLC	Florida
Pediatric Surgery Centers, LLC	Florida
Physicians Surgery Center at Good Samaritan, LLC	Illinois

Physician's Surgery Center of Chattanooga, L.L.C.	Tennessee
Physician's Surgery Center of Knoxville, LLC	Tennessee
Physicians Surgery Center of Tempe, LLC	Oklahoma
Physicians Surgical Center of Ft. Worth, LLP	Texas
Pleasanton Diagnostic Imaging, Inc.	California
PPRE, LLC	Texas
Premier ASC LLC	New Jersey
Premier Endoscopy ASC, LLC	Arizona
PRES/USP Health Ventures, LLC	New Mexico
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
RE Plano Med, Inc.	Texas
Reading Ambulatory Surgery Center, L.P.	Pennsylvania
Reading Endoscopy Center, LLC	Delaware
Reagan Street Surgery Center, LLC	California
Redmond Surgery Center, LLC	Tennessee
Renaissance Surgery Center, LLC	California
Resurgens East Surgery Center, LLC	Georgia
Resurgens Fayette Surgery Center, LLC	Georgia
Resurgens Surgery Center, LLC	Georgia
Richmond ASC Leasing Company, LLC	Virginia
River North Same Day Surgery, L.L.C.	Illinois
Riverside Ambulatory Surgery Center, LLC	Missouri
Rock Hill Surgery Center, LLC	South Carolina
Rockwall Ambulatory Surgery Center, L.L.P.	Texas
Roseville Surgery Center, L.P.	California
Roswell Surgery Center, L.L.C.	Georgia
Sacramento Midtown Endoscopy Center, LLC	California
Safety Harbor ASC Company, LLC	Florida
Saint Agnes/USP Surgery Centers, LLC	California
Saint Francis Surgery Center, L.L.C.	Tennessee
Saint Thomas Campus Surgicare, L.P.	Tennessee
Saint Thomas Surgery Center New Salem, LLC	Tennessee
Saint Thomas/USP – Baptist Plaza, L.L.C.	Tennessee
Saint Thomas/USP Surgery Centers II, LLC	Tennessee
Saint Thomas/USP Surgery Centers, L.L.C.	Tennessee
Same Day Management, L.L.C.	Illinois
Same Day SC of Central NJ, LLC	New Jersey
Same Day Surgery, L.L.C.	Illinois
San Antonio Endoscopy, L.P.	Texas
San Fernando Valley Surgery Center, L.P.	California
San Gabriel Valley Surgical Center, L.P.	California
San Martin Surgery Center, LLC	Nevada

San Ramon Network Joint Venture, LLC	Delaware
Santa Barbara Outpatient Surgery Center, LLC	California
Santa Clarita Surgery Center, L.P.	California
Savannah Endoscopy Ambulatory Surgery Center, LLC	Georgia
Scripps Encinitas Surgery Center, LLC	California
Scripps/USP Surgery Centers, L.L.C.	California
SCNRE, LLC	Texas
Shands/Solantic Joint Venture, LLC	Delaware
Shore Outpatient Surgicenter, L.L.C.	Georgia
Shoreline Real Estate Partnership, LLP	Texas
Shoreline Surgery Center, LLP	Texas
Shrewsbury Surgery Center, LLC	New Jersey
Silicon Valley Outpatient Surgery Centers, LLC	California
Silver Cross Ambulatory Surgery Center, LLC	Illinois
Silver Cross/USP Surgery Centers, LLC	Illinois
Siouxland Surgery Center Limited Liability Partnership	Iowa
SLPA ACO, LLC	Missouri
Solantic Corporation	Delaware
Solantic Development, LLC	Delaware
Solantic Holdings Corporation	Delaware
Solantic of Jacksonville, LLC	Delaware
Solantic of Orlando, LLC	Delaware
Solantic/South Florida, LLC	Delaware
South County Outpatient Endoscopy Services, L.P.	Missouri
South Denver Musculoskeletal Surgical Partners, LLC	Colorado
The Southeastern Spine Institute Ambulatory Surgery Center, L.L.C.	South Carolina
South Florida Ambulatory Surgical Center, LLC	Florida
Southwest Ambulatory Surgery Center, L.L.C.	Oklahoma
Southwest Orthopedic and Spine Hospital Real Estate, LLC	Delaware
Southwest Orthopedic and Spine Hospital, LLC	Arizona
Southwestern Ambulatory Surgery Center, LLC	Pennsylvania
SPC at the Star, LLC	Texas
Specialty Surgery Center of Fort Worth, L.P.	Texas
Specialty Surgicenters, Inc.	Georgia
Spinal Diagnostics and Treatment Centers, L.L.C.	California
Spine & Joint Physician Associates	Texas
SSI Holdings, Inc.	Georgia
St. Joseph's Outpatient Surgery Center, LLC	Arizona
St. Joseph's Surgery Center, L.P.	California
St. Louis Physician Alliance, LLC	Missouri
St. Louis Surgical Center, LLC	Missouri
St. Louis Urology Center, LLC	Missouri
St. Luke's/USP Surgery Centers, LLC	Missouri
St. Mary's Ambulatory Surgery Center, LLC	Virginia
St. Vincent Health/USP, LLC	Indiana
St. Vincent/USP Surgery Centers, LLC	Arkansas

Stockton Outpatient Surgery Center, LLC	California
Suburban Endoscopy Center, LLC	New Jersey
Summit View Surgery Center, LLC	Colorado
Sun View Imaging, L.L.C.	New Mexico
Surgery Affiliate of El Paso, LLC	Texas
Surgery Center at Mount Pleasant, LLC	South Carolina
Surgery Center at University Park, LLC	Florida
Surgery Center of Atlanta, LLC	Georgia
Surgery Center of Canfield, LLC	Ohio
Surgery Center of Columbia, L.P.	Missouri
The Surgery Center at Jensen Beach, LLC	Florida
The Surgery Center at Williamson, LLC	Texas
Surgery Center of Okeechobee, LLC	Florida
Surgery Center of Pembroke Pines, L.L.C.	Florida
Surgery Center of Peoria, L.L.C.	Oklahoma
Surgery Center of Richardson Physician Partnership, L.P.	Texas
Surgery Center of Santa Barbara, LLC	California
Surgery Center of Scottsdale, LLC	Oklahoma
Surgery Center of Tempe Real Estate, L.L.C.	Arizona
Surgery Center of Tempe Real Estate II, L.L.C.	Arizona
Surgery Centers of America II, L.L.C.	Oklahoma
Surgery Centre of SW Florida, LLC	Florida
Surgical Elite of Avondale, L.L.C.	Arizona
Surgical Health Partners, LLC	Tennessee
Surgical Institute Management, LLC	Pennsylvania
Surgical Institute of Reading, LLC	Pennsylvania
Surgical Specialists at Princeton, LLC	New Jersey
Surgicare of Miramar, L.L.C.	Florida
Surginet, Inc.	Tennessee
Surgis Management Services, Inc.	Tennessee
Surgis of Chico, Inc.	Tennessee
Surgis of Phoenix, Inc.	Tennessee
Surgis of Redding, Inc.	Tennessee
Surgis of Victoria, Inc.	Tennessee
Surgis, Inc.	Delaware
Tamarac Surgery Center, LLC	Florida
Tempe New Day Surgery Center, L.P.	Texas
Templeton Imaging, Inc.	California
TENN SM, LLC	Tennessee
Terre Haute Surgical Center, LLC	Indiana
Teton Outpatient Services, LLC	Wyoming
Texan Ambulatory Surgery Center, L.P.	Texas
Texas Endoscopy Centers, LLC	Texas
Texas Health Venture Arlington Hospital, LLC	Texas
Texas Health Venture Baylor Plano, LLC	Texas
Texas Health Venture Carrollton, LLC	Texas

Texas Health Venture Centennial, LLC	Texas
Texas Health Venture Ennis, LLC	Texas
Texas Health Venture Fort Worth, L.L.C.	Texas
Texas Health Venture Granbury, LLC	Texas
Texas Health Venture Heritage Park, LLC	Texas
Texas Health Venture Keller, LLC	Texas
Texas Health Venture Las Colinas, LLC	Texas
Texas Health Venture Mansfield, LLC	Texas
Texas Health Venture Plano Endo, LLC	Texas
Texas Health Venture Plano Parkway, LLC	Texas
Texas Health Venture Plano, LLC	Texas
Texas Health Venture Texas Spine, LLC	Texas
Texas Health Ventures Group L.L.C.	Texas
Texas Orthopedics Surgery Center, LLC	Texas
Texas Regional Medical Center, LLC	Texas
Texas Spine and Joint Hospital, LLC	Texas
Theda Oaks Gastroenterology & Endoscopy Center, LLC	Texas
THV Park Cities, LLC	Texas
THVG Arlington GP, LLC	Delaware
THVG Bariatric GP, LLC	Texas
THVG Bariatric, L.L.C.	Texas
THVG Bedford GP, LLC	Delaware
THVG Bellaire GP, LLC	Delaware
THVG Denton GP, LLC	Delaware
THVG DeSoto GP, LLC	Delaware
THVG DSP GP, LLC	Delaware
THVG Fort Worth GP, LLC	Delaware
THVG Frisco GP, LLC	Delaware
THVG Garland GP, LLC	Delaware
THVG Grapevine GP, LLC	Delaware
THVG Irving-Coppell GP, LLC	Delaware
THVG Lewisville GP, LLC	Delaware
THVG North Garland GP, LLC	Delaware
THVG Park Cities/Trophy Club GP, LLC	Delaware
THVG Rockwall 2 GP, LLC	Texas
THVG Valley View GP, LLC	Delaware
Titan Health Corporation	Delaware
Titan Health of Chattanooga, Inc.	California
Titan Health of Hershey, Inc.	California
Titan Health of Mount Laurel, LLC	California
Titan Health of North Haven, Inc.	California
Titan Health of Pittsburgh, Inc.	California
Titan Health of Pleasant Hills, Inc.	California
Titan Health of Princeton, Inc.	California
Titan Health of Sacramento, Inc.	California
Titan Health of Saginaw, Inc.	California

Titan Health of Titusville, Inc.	California
Titan Health of West Penn, Inc.	California
Titan Health of Westminster, Inc.	California
Titan Management Corporation	California
Titusville Center for Surgical Excellence, LLC	Delaware
TLC ASC, LLC	Florida
TMC Holding Company, LLC	Texas
Toms River Surgery Center, L.L.C.	New Jersey
TOPS Specialty Hospital, Ltd.	Texas
Total Joint Center of St. Louis, LP	Missouri
Total Joint Center of the Northland, LLC	Missouri
Tower Road Real Estate, LLC	Texas
Tower/USP Surgery Centers, LLC	Pennsylvania
TPG Hospital, LLC	Oklahoma
TP Specialty Surgery Center, L.P.	Texas
Treasure Coast ASC, LLC	Florida
The Tresanti Surgical Center, LLC	California
TRMC Holdings, LLC	Texas
Trophy Club Medical Center, L.P.	Texas
True Medical Weight Loss, L.P.	Texas
True Medical Wellness, LP	Texas
True Results Georgia, Inc.	Georgia
True Results HoldCo, LLC	Delaware
True Results Missouri, LLC	Missouri
Tucson Digestive Institute, LLC	Arizona
Turlock Imaging Services, LLC	California
Tuscan Surgery Center at Las Colinas, LLC	Texas
Twin Cities Ambulatory Surgery Center, L.P.	Missouri
UAP Las Colinas Endo, LLC	Texas
UAP Lebanon Endo, LLC	Tennessee
UAP Nashville Endoscopy, LLC	Tennessee
UAP of Arizona, Inc.	Arizona
UAP of California, Inc.	California
UAP of Missouri, Inc.	Missouri
UAP of New Jersey, Inc.	New Jersey
UAP of Oklahoma, Inc.	Oklahoma
UAP of Tennessee, Inc.	Tennessee
UAP of Texas, Inc.	Texas
UAP Scopes, LLC	Missouri
Ulysses True Results NewCo, LLC	Delaware
UMC Surgery Center Lubbock, LLC	Texas
UMC-USP Surgery Centers, LLC	Texas
United Anesthesia Partners, Inc.	Delaware
United Real Estate Development, Inc.	Texas
United Real Estate Holdings, Inc.	Texas
United Surgical Partners Holdings, Inc.	Delaware

United Surgical Partners International, Inc.	Delaware
University Surgery Center, Ltd.	Florida
University Surgical Partners of Dallas, L.L.P.	Texas
Upper Cumberland Physicians' Surgery Center, LLC	Tennessee
USP 12 th Ave Real Estate, Inc.	Texas
USP Acquisition Corporation	Delaware
USP Alexandria, Inc.	Louisiana
USP Assurance Company	Vermont
USP Athens, Inc.	Georgia
USP Atlanta, Inc.	Georgia
USP Austin, Inc.	Texas
USP Bariatric, LLC	Delaware
USP Beaumont, Inc.	Texas
USP Bergen, Inc.	New Jersey
USP Bloomington, Inc.	Indiana
USP Bridgeton, Inc.	Missouri
USP/Carondelet Tucson Surgery Centers, LLC	Arizona
USP Cedar Park, Inc.	Texas
USP Chesterfield, Inc.	Missouri
USP Chicago, Inc.	Illinois
USP Cincinnati, Inc.	Ohio
USP Coast, Inc.	California
USP Columbia, Inc.	Missouri
USP Connecticut, Inc.	Connecticut
USP Corpus Christi, Inc.	Texas
USP Creve Coeur, Inc.	Missouri
USP Denver, Inc.	Colorado
USP Des Peres, Inc.	Missouri
USP Destin, Inc.	Florida
USP Domestic Holdings, Inc.	Delaware
USP Effingham, Inc.	Illinois
USP Encinitas Endoscopy, Inc.	California
USP Fenton, Inc.	Missouri
USP Festus, Inc.	Missouri
USP Florissant, Inc.	Missouri
USP Fort Lauderdale, Inc.	Florida
USP Fort Worth Hospital Real Estate, Inc.	Texas
USP Fredericksburg, Inc.	Virginia
USP Fresno, Inc.	California
USP Frontenac, Inc.	Missouri
USP Gateway, Inc.	Missouri
USP Harbour View, Inc.	Virginia
USP-HMH Surgery Center at Central Jersey, LLC	New Jersey
USP HMH Surgery Center at Shore, LLC	New Jersey
USP Houston, Inc.	Texas
USP Indiana, Inc.	Indiana

USP International Holdings, Inc.	Delaware
USP Jersey City, Inc.	New Jersey
USP Kansas City, Inc.	Missouri
USP Knoxville, Inc.	Tennessee
USP Little Rock, Inc.	Arkansas
USP Long Island, Inc.	Delaware
USP Louisiana, Inc.	Louisiana
USP Lubbock, Inc.	Texas
USP Maryland, Inc.	Maryland
USP Mason Ridge, Inc.	Missouri
USP Mattis, Inc.	Missouri
USP Michigan, Inc.	Michigan
USP Midland Real Estate, Inc.	Texas
USP Midland, Inc.	Texas
USP Midwest, Inc.	Illinois
USP Mission Hills, Inc.	California
USP Montana, Inc.	Montana
USP Morris, Inc.	New Jersey
USP Mt. Vernon, Inc.	Illinois
USP Nevada Holdings, LLC	Nevada
USP Nevada, Inc.	Nevada
USP New Jersey, Inc.	New Jersey
USP Newport News, Inc.	Virginia
USP North Carolina, Inc.	North Carolina
USP North Kansas City, Inc.	Missouri
USP North Texas, Inc.	Delaware
USP Northwest Arkansas, Inc.	Arkansas
USP Office Parkway, Inc.	Missouri
USP Ohio RE, Inc.	Ohio
USP OKC, Inc.	Oklahoma
USP OKC Manager, Inc.	Oklahoma
USP Oklahoma, Inc.	Oklahoma
USP Olive, Inc.	Missouri
USP Orlando, Inc.	Florida
USP Philadelphia, Inc.	Pennsylvania
USP Phoenix, Inc.	Arizona
USP Portland, Inc.	Oregon
USP Reading, Inc.	Pennsylvania
USP Richmond II, Inc.	Virginia
USP Richmond, Inc.	Virginia
USP Sacramento, Inc.	California
USP San Antonio, Inc.	Texas
USP Santa Barbara Surgery Centers, Inc.	California
USP Securities Corporation	Tennessee
USP Silver Cross, Inc.	Illinois
USP Siouxland, Inc.	Iowa

USP Somerset, Inc.	New Jersey
USP South Carolina, Inc.	Delaware
USP Southlake RE, Inc.	Texas
USP/SOS Joint Venture, LLC	Oklahoma
USP St. Louis, Inc.	Missouri
USP St. Louis Urology, Inc.	Missouri
USP St. Peters, Inc.	Missouri
USP Sunset Hills, Inc.	Missouri
USP Tennessee, Inc.	Tennessee
USP Texas Air, L.L.C.	Texas
USP Texas, L.P.	Texas
USP TJ STL, Inc.	Missouri
USP Torrance, Inc.	California
USP Tucson, Inc.	Arizona
USP Turnersville, Inc.	New Jersey
USP Virginia Beach, Inc.	Virginia
USP 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
USPI Group Holdings, Inc.	Delaware
USPI Holdings, Inc.	Delaware
USPI Physician Strategy Group, LLC	Texas
USPI San Diego, Inc.	California
USPI Stockton, Inc.	California
USPI Surgical Services, Inc.	Delaware
Utica ASC Partners, LLC	Michigan
Utica/USP Tulsa, L.L.C.	Oklahoma
Ventana Surgical Center, LLC	California
Veroscan, Inc.	Delaware
VHS San Antonio Imaging Partners, L.P.	Delaware
Vestavia Surgical Services, LLC	Alabama
Victoria Ambulatory Surgery Center, L.P.	Delaware
Virtua-USP Princeton, LLC	New Jersey
Walker Street Imaging Care, Inc.	California
Warner Park Surgery Center, LLC	Arizona
Webster Ambulatory Surgery Center, L.P.	Missouri
Wellstar/USP Joint Venture I, LLC	Georgia
Wellstar/USP Joint Venture II, LLC	Georgia
West Bozeman Surgery Center, LLC	Montana
Westlake Hospital, LLC	Texas
WHASA, L.C.	Texas
Willamette Spine Center Ambulatory Surgery, LLC	Delaware
Wilmington Endoscopy Center, LLC	North Carolina
Winter Haven Ambulatory Surgical Center, L.L.C.	Florida

YNHHSC/USP Surgery Centers, LLC	Connecticut

Exhibit 23(a)

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement Nos. 033-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482, 333-74216, 333-151884, 333-151887, 333-166767, 333-166768, 333-191614, 333-196262, 333-212844 and 333-212846 on Form S-8 of our reports dated February 25, 2019, 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, 2018.

/s/ Deloitte & Touche LLP
Dallas, Texas
February 25, 2019

Exhibit 23(b)

CONSENT OF INDEPENDENT ACCOUNTANTS

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 033-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482, 333-74216, 333-151884, 333-151887, 333-166767, 333-166768, 333-191614, 333-196262, 333-212844 and 333-212846) of Tenet Healthcare Corporation of our report dated December 20, 2018 relating to the financial statements of Texas Health Ventures Group L.L.C., and its subsidiaries, which appears in this Annual Report on Form 10-K of Tenet Healthcare Corporation.

/s/ PricewaterhouseCoopers LLP
Dallas, Texas
February 25, 2019

Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Ronald A. Rittenmeyer, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 25, 2019

/s/ RONALD A. RITTENMEYER

Ronald A. Rittenmeyer

Executive Chairman and Chief Executive Officer

Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 25, 2019

/s/ DANIEL J. CANCELMI

Daniel J. Cancelmi

Chief Financial Officer

Exhibit 32

Certifications Pursuant to Section 1350 of Chapter 63
of Title 18 of the United States Code

We, the undersigned Ronald A. Rittenmeyer and Daniel J. Cancelmi, being, respectively, the Executive Chairman and Chief Executive Officer and the 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, 2018 (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 25, 2019	/s/ RONALD A. RITTENMEYER
	Ronald A. Rittenmeyer
	Executive Chairman and Chief Executive Officer
Date: February 25, 2019	/s/ DANIEL J. CANCELMI
	Daniel J. Cancelmi
	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.