Original Application

Saint Francis Hospital-Bartlett

CN1701-004

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

JAN 13 '17 PM 3:50

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. ***Name of Facility, Agency, or Institution***

Saint Francis Hospital-Bartlett
Name

2986 Kate Bond Road — Shelby
Street or Route — County

Bartlett — TN — 38133-4003
City — State — Zip Code

Website address: https?//www.saintfrancisbartlett.com

Note: The facility's name and address ***must be*** *the name and address of the project and* ***must be*** *consistent with the Publication of Intent.*

2. ***Contact Person Available for Responses to Questions***

Kim Harvey Looney — Attorney
Name — Title

Waller Lansden Dortch & Davis LLP — kim.looney@wallerlaw.com
Company Name — Email address

511 Union Street — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Attorney — 615-850-8722 — 615-244-6804
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

1. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

   Response: The applicant is seeking to establish a freestanding emergency department, which will be an outpatient department of Saint Francis Hospital - Bartlett, with the same licensure classification as the main emergency department on the campus of SFH-Bartlett. It will comply with the CMS provider-based regulations. The FSED will include certain diagnostic imaging equipment necessary for the operation of an FSED including CT, X-Ray and ultrasound. The FSED is being built with 12 treatment rooms, and will staff and operate them in accordance with needs of the service area residents. The proposed FSED is located approximately 10 miles from SFH-Bartlett, which is the closest hospital. The FSED will be operated 7 days a week, 24 hours a day, 365 days a year. No health services will be initiated, and no beds are affected as a result of this application. The applicant has no outstanding but unimplemented CONs.

2) Ownership structure;

   Response: The FSED will be an outpatient department of SFH-Bartlett and as such, will have the same ownership structure as the hospital.

3) Service area;

   Response: The service area includes portions of Shelby, Fayette, Haywood and Tipton Counties. Specifically it includes nine (9) zip codes: 38002, 38028, 38053 and 38054 (Shelby County), 38060 and 38068 (Fayette County), 38012 and 38069 (Haywood County), and 38049 (Tipton County).

4) Existing similar service providers;

   Response: None of the service area counties currently have an FSED. The only hospital in the zip code service area is SFH-Bartlett, so it provides the only emergency department services. Utilization for Shelby County providers and the hospital in Tipton County are included in the application because portions of those counties are included in the service area. Overall, utilization for emergency services is growing at these hospitals. Utilization ranged from 1,026 per treatment room to 1,966 per treatment room for 2015 for these facilities. There are no hospitals in Fayette or Haywood counties. Haywood Park Community Hospital closed in 2014 and Methodist Fayette closed in 2015, leaving those communities without convenient access to emergency services. The last full year before they closed, Haywood Park reported 5,460 emergency department visits and Methodist Fayette reported 7,580 emergency department visits, for a total of 13,040 visits. In 2015, SFH-Bartlett had 1,280 visits per treatment room, increasing to 1,323 visits per treatment room for 2016. SFH-

Bartlett expects to have greater than 1,500 visits per treatment room no later than 2019.

5) Project cost;

Response: The applicant estimates the project costs to be $12,828,763, of which $5,352,475 are the construction costs. Capital Growth MedVest intends to develop the project and the applicant intends to lease the building from them. The applicant is only responsible for the funding of the costs of the fixed and moveable equipment of approximately $2.3M.

6) Funding;

Response: The applicant anticipates its portion of the costs - the fixed and moveable equipment of $2.3M - will be funded from either debt or cash flow from operations, or a combination thereof. In addition, Tenet has a line of credit available for undertaking projects such as the proposed FSED. The majority of project costs will be paid from operating revenues after the project is operational.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: The applicant anticipates that the FSED will generate a positive cash flow during its second year of operation.

8) Staffing.

Response: The applicant anticipates providing 27.59 FTE direct patient care staff, including RNs, triage nurses, and lab and radiology technicians. There will be 6.2 FTE patient care positions, including directors/administrators, secretaries and front desk positions. In addition there will be 13.0 FTE contractual staff.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: The applicant, SFH-Bartlett, is an acute care hospital with 196 licensed beds. In 2013, it increased its emergency department treatment rooms from 19 to 33. From 2013 to 2016, its utilization increased from 36,616 visits to 43,644 visits, or an increase of 19%. In 2016, the number of visits per treatment room was 1,323. SFH-Bartlett anticipates having 1,500 visits per treatment room in the hospital ED sometime in 2019 which is also the first full year of operation for the FSED. The

planning horizon for the project is 4 years out, or 2021, so it is important to consider what resources might be needed in that year and beyond. The State is in the process of developing the Memphis Regional Megasite. This site is a 4,100 acre site backed by a $106 million State infrastructure investment. It is located off of I40 approximately 18 miles from the proposed FSED site. It will be extremely beneficial to recruiting businesses to locate here for their workers to have convenient access to health care services. Any growth in population is not included in any current population projections and it would be expected that as industry locates at this site, they will bring a significant workforce with them, increasing the need for the proposed FSED.

Given its existing and projected utilization, SFH-Bartlett will need additional ED capacity in the next couple of years. It is not possible to increase space for the ED within the existing footprint of SFH-Bartlett. To add capacity would require major construction and be extremely disruptive to patients, family members and staff during the process. SFH-Bartlett is seeking to add additional ED capacity to its service area as well as to bring an essential health care service closer to the primarily rural patient population that is in need of that service.

The FSED will be located off of I40 and Airline Road in Arlington, approximately 10 miles from the SFH-Bartlett campus. This location is 1.3 miles from the Fayette County border and because of its proximity to I40 and other major Shelby County highways, it is expected to provide faster access to emergency services. It is important that area residents have convenient access to emergency services as time to treatment is generally a critical factor in providing emergency care.

The FSED will include certain diagnostic imaging equipment necessary for the operation of a FSED including CT, X-Ray and ultrasound. The FSED will be built with twelve (12) treatment rooms, and it be will staffed and operate as many treatment rooms as are necessary to meet the needs of the service area population. By adding an FSED, SFH-Bartlett will be able to add to its capacity for ED services, while at the same time locating the service closer to a patient population which is in need of these services. There are no FSEDs in the applicant's service area. The only hospital in the zip codes for the applicant's service area is SFH-Bartlett.

Utilization for Shelby County providers and the hospital in Tipton County are included in the application because portions of those counties are included in the service area. Overall, utilization for emergency services is growing at these hospitals; it ranged from 1,026 visits per treatment room to 1,966 visits per treatment room for 2015. The applicant's service area lost 2 hospital providers in recent years. Haywood Park Community Hospital closed in 2014 and Methodist Fayette closed in 2015, leaving those communities without convenient access to emergency services. The last full year each of the hospitals was open, there was a combined 13,040 visits in their emergency departments. This project seeks to help fill the void in availability of emergency services and increase access for emergency services by providing another option in close proximity to the service area residents.

The applicant projects 5,550 visits the first full year of operation (2019) increasing to 6,656 visits the second full year of operation (2020), with 25% or more of those coming from patients who would otherwise choose to receive services from SFH-Bartlett. The FSED is being built with 12 treatment rooms, and will staff and operate them in accordance with needs of the service area residents. As utilization at SFH-

Bartlett increase, it is important to expand the services and options available for emergency services. An FSED is a viable option to provide increased capacity for ED services. Locating the FSED 10 miles away from SFH-Bartlett also allows for increased access by patients who might otherwise have to travel farther to receive these services, provides a viable option and allows for patient choice.

2) Economic Feasibility;

Response: The applicant estimates the project costs to be $12,828,763, of which $5,352,475 are the construction costs. Capital Growth MedVest intends to develop the project and the applicant intends to lease the building from them. The applicant is only responsible for the funding of the costs of the fixed and moveable equipment of approximately $2.3M.

The total square footage is 15,240 square feet, with construction costs of $5,352,475 for a construction cost per square foot of $351.21. The median square footage cost for hospital projects from 2013-2015 is $308.43, while the 3rd quartile for square footage cost for hospital projects is $374.32. Thus, the applicant's projected square footage construction cost is less than the 3rd quartile for hospital projects based on data from 2013-2015. Several FSEDs have been approved in Tennessee in recent years - CN1202-008A for Horizon Medical Center in Dickson ($295 per square foot); CN1508-029 for Sumner Regional Medical Center ($288 per square foot); and CN1508-031 for TriStar Summit Medical Center ($374.32 per square foot). Given that construction costs have been increasing rapidly over the past several years, applicant's construction costs are reasonable, and compare favorably to other FSED projects that have been approved. The applicant anticipates that the project will have a positive cash flow in the first full year of operation.

3) Appropriate Quality Standards; and

Response: The applicant will measure certain quality standards for the FSED, similar to those applied to the SFH-Bartlett ED, including potentially some of the following: aspirin at arrival, door to diagnostic evaluation by a qualified medical personnel, median time from ED arrival to departure for discharged ED patients, median time transfer to another facility for acute coronary intervention and median time to pain management for long bone fracture.

4) Orderly Development to adequate and effective health care.

Response: The proposed FSED contributes to the orderly development of adequate and effective health care. SFH-Bartlett is the closest hospital to the FSED. At 10 miles from SFH-Bartlett, the FSED is located far enough away to provide increased access for significant portions of the service area population. SFH-Bartlett estimates that at least 25% of the patients for this FSED will be a patient population it already serves who will choose to receive these emergency services closer to home.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: N/A

4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

Saint Francis Hospital - Bartlett, Inc. — 469-893-2000
Name — Phone Number
1445 Ross Avenue, Suite 1400 — Dallas
Street or Route — County
Dallas — TX — 75202
City — State — Zip Code

B. Type of Ownership of Control (Check One)

A.	Sole Proprietorship	____	F.	Government (State of TN or Political Subdivision)	____
B.	Partnership	____	G.	Joint Venture	____
C.	Limited Partnership	____	H.	Limited Liability Company	____
D.	Corporation (For Profit)	X	I.	Other (Specify) ____	____
E.	Corporation (Not-for-Profit)	____			

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A.**

Response: See copy of corporate documents included as Attachment Section A-4A.

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

5. *Name of Management/Operating Entity (If Applicable)*

N/A
Name

Street or Route — County

City — State — Zip Code

Website address: ____

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5.** **Response:** Not applicable.

6A. ***Legal Interest in the Site of the Institution*** ***(Check One)***

A.	Ownership	_____	D.	Option to Lease	X
B.	Option to Purchase	_____	E.	Other (Specify) _____	_____
C.	Lease of Years	_____			

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

Response: See copy of Option to Lease included as Attachment Section A-6A.

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

a. Size of site (***in acres***);

b. Location of structure on the site;

c. Location of the proposed construction/renovation; and

d. Names of streets, roads or highway that cross or border the site.

Response: See plot plan included as Attachment Section A-6B-1.

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

Response: See floor plan included as Attachment Section 6-B-2.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

Response: The proposed site is easily accessible by car from Interstate 40; located just off Interstate-40, close to New Airline Road and Arlington Trail. The FSED will be approximately 10 miles from SFH-Bartlett. There is no public transportation in this area. Patients generally will arrive on their own by car or by ambulance.

7. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

A. Hospital (Specify) _____ X
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty _____
C. ASTC, Single Specialty _____
D. Home Health Agency _____
E. Hospice _____
F. Mental Health Hospital _____
G. Mental Health Residential Treatment Facility _____
H. Mental Retardation Institutional Habilitation Facility (ICF/MR) _____
I. Nursing Home _____
J. Outpatient Diagnostic Center _____
K. Recuperation Center _____
L. Rehabilitation Facility _____
M. Residential Hospice _____
N. Non-Residential Methadone Facility _____
O. Birthing Center _____
P. Other Outpatient Facility (Specify) _____
Q. Other (Specify) FSED X

Check appropriate lines(s).

8. ***Purpose of Review*** ***(Check) as appropriate--more than one response may apply)***

A. New Institution _____
B. Replacement/Existing Facility _____
C. Modification/Existing Facility _____
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) _____ _____
E. Discontinuance of OB Services _____
F. Acquisition of Equipment _____
G. Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*
H. Change of Location _____
I. Other (Specify) FSED X

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number: 440228

Medicaid Provider Number: 11859B

Certification Type: Hospital

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare _____Yes _____No X N/A Medicaid/TennCare _____Yes_____No X N/A

4844-3123-7952.22

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	144					144
2) Surgical						
3) ICU/CCU	32					32
4) Obstetrical	10					10
5) NICU	10					10
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	196					196

*Beds approved but not yet in service **Beds exempted under 10% per 3 year provision

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

Response: N/A

C. **Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.**

Response: N/A

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

11. **Home Health Care Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

Response: N/A

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart **Response:** See chart below.

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
FSED						15,240	15,240
Unit/Department GSF Sub-Total							15,240
Other GSF Total							
Total GSF							15,240
*Total Cost							$5,352,475
**Cost Per Square Foot							$351.21
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)*					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile X☐Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomography (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment. **Response:** N/A

☐ Linear Accelerator	Mev _____	Types:	☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____
	Total Cost*: _____		☐ By Purchase ☐ By Lease
	☐ New ☐ Refurbished		☐ If not new, how old? (yrs) _____
			Expected Useful Life (yrs) _____
☐ MRI	Tesla: _____	Magnet:	☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____
	Total Cost*: _____		☐ By Purchase ☐ By Lease
	☐ New ☐ Refurbished		☐ If not new, how old? (yrs) _____
			Expected Useful Life (yrs) _____
☐ PET	☐ PET only ☐ PET/CT ☐ PET/MRI		
	Total Cost*: _____		☐ By Purchase ☐ By Lease
	☐ New ☐ Refurbished		☐ If not new, how old? (yrs) _____
			Expected Useful Life (yrs) _____

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Response: N/A

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

Response: N/A

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

Response: N/A

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

Response: N/A

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant toT.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

Construction, Renovation, Expansion and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services or medical equipment will be reviewed under the standards for those specific activities.

Response: N/A

2. For relocation or replacement of an existing licensed health care institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

Response: N/A

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response: N/A

3. For renovation or expansion of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project:

Response: The applicant currently has a significant number of patients from the zip codes that comprise the service area. Methodist Healthcare - Fayette closed in 2015, and Haywood Park Community Hospital closed in 2014, leaving those areas without convenient access to emergency services. Many of those patients have chosen to receive emergency services at SFH-Bartlett and this application will continue to assist in filling that void. It will provide convenient access to necessary emergency services for the primarily rural patient population.

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Response: The existing SFH-Bartlett physical plant expanded from 19 emergency treatment rooms to 33 treatment rooms in 2013. Since that time, utilization has grown from 36,616 visits to 43,644 visits in 2016, or an increase of 19%. It is not possible to increase space for the ED within the existing footprint of SFH-Bartlett. To add capacity would require major construction and be extremely disruptive to patients, staff and family members during the process. SFH-Bartlett is seeking to add additional ED capacity to its service area as well as to bring an essential health care service closer to the patient population that is in need of that service.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response: The applicant receives a significant number of ED patients from the projected service area. It is consistent with the applicant's long-range plan, as well as that for Tenet, to develop free-standing emergency departments where the patient population can benefit from having more convenient access to such necessary health care services.

Tenet's core business is Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, urgent care centers, freestanding emergency departments, physician practices and health plans. At December 31, 2015, Tenet had 69 diagnostic imaging centers, 14 satellite emergency departments, 13 ambulatory surgery centers and seven urgent care centers operated as departments of its hospitals and under the same license, as well as 71 separately licensed, freestanding outpatient centers – typically at locations complementary to its hospitals – consisting of eight diagnostic imaging centers, five emergency departments, three ambulatory surgery centers and 55 urgent care centers, the majority of which are operated under its national MedPost brand. Tenet believes that strong concentrations of hospital beds and outpatient centers within market areas help it reduce management, marketing and other expenses, and more efficiently utilize resources.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment – Section – Need-3.**

Response: The applicant's service area for the FSED includes portions of Shelby, Fayette, Haywood and Tipton Counties. Specifically it includes nine (9) zip codes: 38002,

38028, 38053 and 38054 (Shelby County), 38060 and 38068 (Fayette County), 38012 and 38069 (Haywood County), and 38049 (Tipton County).

This service area is reasonable because it is based on the existing service area for emergency department visits for SFH-Bartlett. A zip code level map are included as Attachment Section C, Need-3.

Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents SFH-Bartlett	% of total procedures
Fayette	3.043	8%
Haywood	159	.4%
Tipton	2,476	6%
Shelby	34,020	86%
TOTAL	39,698	100%

Service Area Counties	Projected Utilization-County Residents SFH-Bartlett Year 1	% of total procedures
Fayette	4,060	9%
Haywood	390	1%
Tipton	2,719	6%
Shelby	36,629	84%
Total	43,823	100%

Service Area Counties	Projected Utilization-County Residents FSED Project Year 1	% of total procedures
Fayette	1,383	25%
Haywood	315	6%
Tipton	306	5%
Shelby	3,546	64%
Total	5,550	100%

Service Area Counties	Projected Utilization-County Residents FSED Project Year 2	% of total procedures
Fayette	1,760	26%
Haywood	330	5%
Tipton	355	5%
Shelby	4,211	63%
Total	6,656	100%

Response: The applicant projects utilization for the first two years of the FSED as shown above. The applicant expects that at least 20-25% of these visits will be shifted from SFH-Bartlett due to the difference in proximity for the patients to the FSED. The applicant anticipates a difference in the percentage of procedures from each county because the existing SFH-Bartlett ED sees a greater percentage of patients from Shelby County than the FSED is expected to. As the FSED is located 10 miles from SFH-Bartlett, it makes sense that the patients from the Shelby County areas located in closest proximity to SFH-Bartlett will continue to receive emergency services at SFH-Bartlett because they are more convenient than the proposed FSED location. This results in a greater percentage of the patient visits coming from areas farther out from Bartlett, where patients do not currently have the convenient access to emergency services and will welcome a facility located closer to them.

The applicant has discussed this project with area business leaders and they are very excited at the prospect of having a FSED located closer to them.

County Level Map

Proposed Service Area

A. 1) Describe the demographics of the population to be served by the proposal.

2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Fayette	45,626	49,441	8.4%	N/A	N/A	N/A	N/A	43.7	$54,890	5,351	13.9%	7,284	16%
Haywood	18,348	18,048	-1.6%	N/A	N/A	N/A	N/A	39.9	$34,182	4,107	22.8%	6,047	33%
Shelby	964,804	986,423	2.2%	N/A	N/A	N/A	N/A	34.9	$46,224	196,471	21.4%	281,655	29.2%
Tipton	68,274	72,169	5.7%	N/A	N/A	N/A	N/A	37.0	$53,669	8,292	13.6%	14,293	20.9%
Service Area Total	1,097,052	1,126,081	2.6%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	309,279	28.2%
State of TN Total	6,887,572	7,179,512	4.2%	N/A	N/A	N/A	N/A	38.4	$45,219	1,117,594	17.6%	1,559,209	22.6%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

Response: Please see table below for population by zip code. It is not available by age group, but only for the total population by zip code. With the exception of one zip code, all are expected to increase by 2021 and overall, the projected increase is 2.6 percent.

ZIP	County	State	2017 Adj. Pop	2021 Adj. Pop	% Change
38002	Shelby	TN	41,561	43,413	4.5%
38012	Haywood	TN	14,763	14,785	.1%
38028	Shelby	TN	6,948	7,197	3.6%
38049	Tipton	TN	4,940	4,981	1%
38053	Shelby	TN	29,390	29,794	1.4%
38054	Shelby	TN	63	63	0%
38060	Fayette	TN	10,512	10,982	4.5%
38068	Fayette	TN	10,865	10,955	1%
38069	Haywood	TN	2,615	2,612	0%
Total			**121,657**	**124,782**	**2.6%**

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: The applicant serves all patient populations and does not discriminate on the basis of age, sex, minorities or income. Any accommodations that might need to be made for pediatric or geriatric patients will be made.

Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response: There are no FSEDs in the applicant's service area. There are no hospitals in Fayette or Haywood Counties, since Methodist closed its hospital in Fayette County in 2015 and Haywood Park Community Hospital closed in 2014, so there are no emergency department services available in those counties. SFH-Bartlett expanded its emergency department capacity in 2013 from 19 to 33 treatment rooms. Utilization for emergency departments in these counties is included below:

Emergency Department Utilization

2013-2015

Hospital	Treatment Rooms	2013 Visits	2014 Visits	2015 Visits	Visits/ Room
Baptist Memphis	54	60,274	62,857	62,492	1,157
Baptist - Collierville	13	16,714	14,690	17,219	1,325
Baptist-Tipton	13	20,363	19,367	20,954	1,612
Baptist-Women's	8	N/A	N/A	10,172	1,271
Delta Medical Center	13	26,459	23,963	25,557	1,966
Haywood Park Community Hospital	N/A	5,460	2,659	0	N/A
Methodist-LeBonheur	N/A	55,358	87,684	93,442	N/A
Methodist University	54	62,587	67,821	70,051	1,297
Methodist South	27	62,300	62,822	65,601	1,773
Methodist North	43	69,062	70,872	72,247	1,680
Methodist Germantown	38	54,914	53,817	57,468	1,512
Methodist-Fayette	N/A	7,991	7,580	1,408	N/A
Regional One	51	55,963	53,187	52,327	1,026
SFH-Park	43	43,989	49,746	54,522	1,268
SFH-Bartlett	33	36,001	38,145	42,220	1,280

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015.
Note: Haywood Park Community Hospital closed in 2014 and Methodist Fayette closed in 2015.

In 2013, SFH-Bartlett increased the number of its emergency treatment rooms from 19 to 33. SFH-Bartlett had 42,220 visits to its emergency room in 2015, or 1,280 visits per treatment room. That number represents an increase of 17% between 2013 and 2015. In 2016, that number increased to 43,644, or 1,323 per treatment room. The applicant anticipates that the number of visits per treatment room will meet or exceed 1,500 sometime in 2019, which is the first year the FSED is expected to be open. Overall, in 2015, the hospitals in Shelby and Tipton Counties had a total of 550,830 visits, 390 treatment rooms, and 1,413 visits per treatment room.

Please see table below for the distance between existing or closed facilities and the proposed FSED location. It is important to locate emergency services as close to the patient population as possible, which in this situation is primarily a rural population without viable treatment options. Generally, time to treatment can be critical. SFH-Bartlett is the closest facility at 10 miles. Haywood Park was the farthest away at 36 miles. The applicant anticipates drawing patients from the western portion of Haywood County, which is a straight shot to the proposed FSED. The addition of this facility will allow more convenient access to a necessary health care service for much of the rural service area population as allowing patients to have a choice in their health care provider for emergency services.

Distance from Proposed FSED

Facility	Miles from I-40 and Airline Road
Saint Francis Hospital-Bartlett	10
Methodist LeBonheur Germantown Hospital	17
Haywood Park Community Hospital (closed)	36
BMH-Memphis	18
LeBonheur Children's Hospital	24
Methodist North Hospital	17
RMH for Women	22
Saint Francis Hospital	20
BMH-Collierville	22
Methodist University Hospital	24
Methodist Fayette (closed)	20
Baptist Tipton	22
Regional One Health	28

5. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Please see table below for utilization data for SFH-Bartlett.

Saint Francis Hospital-Bartlett

Utilization Data

Year	Number of Beds Licensed/Staffed	Admissions	Patient Days	Occupancy Rate Licensed/Staffed
2013	196/156	6,422	30,737	44%/54%
2014	196/156	6,992	33,223	46%/58%
2015	196/156	7,201	35,292	49%/62%
2016	196/156	7,274	35,292	49%/62%
2017	196/156	7,419	35,998	50%/63%
2018	196/164	7,567	36,718	51%/61%

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015. Internal data from SFH-Bartlett. Projections based on historical data.

Utilization at SFH-Bartlett has steadily increased between 2013 to 2015, according to the data from the JARs. Patient days grew 15% during that time period and staffed bed occupancy grew from 54% to 62% during this same time period.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   A. All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

   Response: Please see Project Costs Chart. The total costs of the project are $12,828,763. These costs are reasonable based on the scope of the project, which is to build a FSED with 12 treatment rooms.

   B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   Response: The applicant has included the total cost of construction of the project, which is higher than the fair market value of the total amount of the lease payments over the initial term of the lease.

   C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

   Response: The applicant anticipates a cost of just over $2.3 million for fixed and moveable equipment, which is the only cost for which it is responsible.

   D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

   Response: The total square footage is 15,240 square feet, with construction costs of $5,352,475 for a construction cost per square foot of $351.21. The median square footage cost for hospital projects from 2013-2015 is $308.43, while the 3rd quartile for square footage cost for hospital projects is $374.32. Thus, the applicant's projected square footage construction cost is less than the 3rd quartile for hospital projects based on data from 2013-2015. Several FSEDs have been approved in Tennessee in recent years - CN1202-008A for Horizon Medical Center in Dickson ($295 per square foot); CN1508-029 for Sumner Regional Medical Center ($288 per square foot); and CN1508-031 for TriStar Summit Medical Center ($374.32 per square foot). Given that construction costs have been increasing rapidly over the past several years, these construction costs are reasonable.

   E. For projects that include new construction, modification, and/or renovation— **documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

      1) A general description of the project;

      2) An estimate of the cost to construct the project;

3) A description of the status of the site's suitability for the proposed project; and

4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Response: Please see architect letter included as Attachment Section C, Economic Feasibility-1-E.

JAN 13 '17 PM 8:51

PROJECT COST CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	461,198.00
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	150,000.00
3.	Acquisition of Site	1,590,520.00
4.	Preparation of Site	1,450,000.00
5.	Total Construction Costs	5,352,475.00
6.	Contingency Fund	380,049.00
7.	Fixed Equipment (Not included in Construction Contract)	1,075,043.00
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	1,224,988.00
9.	Other (Specify) Soft cost, Management & Development Fees	672,912.00
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) _____	
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	299,118.00
2.	Underwriting Costs	81,500.00
3.	Reserve for One Year's Debt Service	N/A
4.	Other (Specify) Expenses, Insurance & Testing	90,500.00
D.	Estimated Project Cost (A+B+C)	12,828,763.00
E.	CON Filing Fee	73,765.39
F.	Total Estimated Project Cost (D+E) **TOTAL**	12,902,528.39

4844-3123-7952.22

2. Identify the funding sources for this project.

   Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

   _____ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

   _____ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

   _____ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

   _____ D. Grants – Notification of intent form for grant application or notice of grant award;

   X E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

   X F. Other – Identify and document funding from all other sources.

   Response: The applicant anticipates its portion of the costs - the fixed and moveable equipment of $2.3M - will be funded from either debt or cash flow from operations, or a combination thereof from Tenet, its parent company. In addition, Tenet has a line of credit available for undertaking projects such as the proposed FSED. The majority of project costs will be paid from operating revenues after the project is operational. See Attachment Section C, Economic Feasibility-2 for funding documentation.

3. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

   Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

HISTORICAL DATA CHART

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure, e.g., 1,000 ***patient days***, 500 visits)	30,737	33,223	36,676
B. Revenue from Services to Patients			
1. Inpatient Services	**$ 353,307,149**	**$ 379,572,895**	**$ 447,469,820**
2. Outpatient Services	291,457,377	322,951,591	378,654,756
3. Emergency Services			
4. Other Operating Revenue (Specify) Gift Shop, Cafeteria	126,649	100,896	379,707
Gross Operating Revenue	**$634,891,175**	**$702,625,382**	**$826,504,283**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	**$ 512,953,235**	**$ 573,130,178**	**$ 677,888,075**
2. Provision for Charity Care	315,265	3,686,452	4,552,862
3. Provisions for Bad Debt	14,803,643	15,839,479	17,425,039
Total Deductions	**$ 528,072,143**	**$ 592,656,109**	**$ 699,865,976**
NET OPERATING REVENUE	**$ 106,819,032**	**$ 109,969,273**	**$ 126,638,307**
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	14,117,201	14,503,473	18,335,644
b. Non-Patient Care	16,163,104,	16,315,749	15,449,234
2. Physician's Salaries and Wages	0	0	0
3. Supplies	18,307,492	19,706,664	21,855,477
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
5. Management Fees:			
a. Paid to Affiliates	0	0	0
b. Paid to Non-Affiliates	0	0	0
6. Other Operating Expenses	$34,008,266	$32,792,436	$41,579,482
Total Operating Expenses	**$ 82,596,063**	**$ 83,318,322**	**$ 97,219,837**
E. **Earnings Before Interest, Taxes and Depreciation**	**$ 24,229,969**	**$ 26,650,951**	**$ 29,418,470**
F. Non-Operating Expenses			
1. Taxes	$ 7,674,617	$ 7,492,120	$ 8,787,865
2. Depreciation	5,262,406	5,306,864	7,714,668
3. Interest	130,954	65,329	129,548
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	**$13,067,977**	**$12,864,313**	**$16,632,081**
NET INCOME (LOSS)	**$11,154,992**	**$13,786,638**	**$12,786,389**

Chart Continues Onto Next Page

NET INCOME (LOSS)	$	$	$
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$	$	$
NET BALANCE	$	$	$
DEPRECIATION	$	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$	$	$

X Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 3,279,474	$ 4,168,072	$ 4,355,721
2. Contract Labor	634,460	800,627	1,112,831
3. Imaging Interpretation Fees			
4.			
5.			
6.			
7.			
Total Other Expenses	**$ 3,913,934**	**$ 4,968,699**	**$ 5,468,552**

4. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

   The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

PROJECTED DATA CHART

Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 1	Year 2
A.	Utilization Data (visits)	5,591	6,656
B.	Revenue from Services to Patients		
	1. Inpatient Services	$0	$0
	2. Outpatient Services	0	0
	3. Emergency Services	$15,874,322	$19,569,476
	4. Other Operating Revenue (Specify)		
	Gross Operating Revenue	$15,874,322	$19,569,476
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$9,984,000	$12,020,000
	2. Provision for Charity Care	914,000	1,090,000
	3. Provisions for Bad Debt	405,000	503,000
	Total Deductions	$11,303,000	$13,613,000
NET OPERATING REVENUE		$4,571,322	$5,956,476
D.	Operating Expenses		
	1. Salaries and Wages	2,743,377	2,839,395
	a. Direct Patient Care	2,437,201	2,522,503
	b. Non-Patient Care	306,176	316,892
	2. Physician's Salaries and Wages	0	0
	3. Supplies	57,807	75,060
	4. Rent		
	a. Paid to Affiliates	0	0
	b. Paid to Non-Affiliates	1,136,723	1,141,790
	5. Management Fees:		
	a. Paid to Affiliates	0	0
	b. Paid to Non-Affiliates	0	0
	6. Other Operating Expenses	1,326,421	1,459,307
	Total Operating Expenses	$ 5,264,328	$ 5,515,552
E.	**Earnings Before Interest, Taxes and Depreciation**	($ 258,545)	$,981,298
F.	Non-Operating Expenses		
	1. Taxes	$ 240,000	$ 738,000
	2. Depreciation	245,000	245,000
	3. Interest	0	0
	4. Other Non-Operating Expenses	0	0
	Total Non-Operating Expenses	$ 485,000	$ 983,000
NET INCOME (LOSS)		($ 743,545)	($ 1,702)

Chart Continues Onto Next Page

NET INCOME (LOSS)	($ 762,298)	($ 23,650)
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ 0	$ 0
2. Annual Capital Expenditure	0	0
Total Other Deductions	$ 0	$ 0
NET BALANCE	($ 762,298)	($ 23,650)
DEPRECIATION	$ 245,000	$ 245,000
FREE CASH FLOW (Net Balance + Depreciation)	($ 517,298)	$ 221,350

□ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 1	Year 2
1. Professional Services Contract	**$ 323,801**	**$ 333,516**
2. Contract Labor		
3. Imaging Interpretation Fees		
4.		
5.		
6.		
7.		
Total Other Expenses	**$ 323,801**	**$ 333,516**

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year-SFB-2015	Current Year-SFH-2016	Year One-FSED-2019	Year Two-FSED-2020	% Change (Year 1 to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	5,793	6,209	3,848	3,782	-1.7%
Deduction from Revenue *(Total Deductions/Utilization Data)*	4,786	5,055	2,747	2,638	-3.9%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	1,007	1,153	1,101	1,144	+3.9%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: See table above for gross charges both for SFH-Bartlett ED and the proposed FSED. Because the overall acuity level of the patients is expected to be lower than the acuity level of the patients treated at the SFH-Bartlett ED, the charges are less for the FSED.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Please see information below:

CPT Code	Procedure Level	Current Rate
99281	Level 1	$56.53
99282	Level 2	$102.68
99283	Level 3	$185.38
99284	Level 4	$306.20
99285	Level 5	$450.21

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: The applicant expects to reach the break-even point during the first year of operation, and generate positive cash flow in first year of operation as well. Included as Attachment C, Economic Feasibility 6-A is the 10-K SEC filing for Tenet, the ultimate parent company of the applicant.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	.21	.20	.23	-.05666	.1647

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: N/A. The applicant will not have any long-term debt for this project.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: Please see the chart below for the applicant's projected payor mix

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	3,493,498	22
TennCare/Medicaid	1,049,825	7
Commercial/Other Managed Care	8,592,683	54
Self-Pay	1,201,097	7.6
Charity Care	158,743	1.0
Other (Specify) Private/Exchange	1,381,313	8.7
Total	15,874,322	100

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: Please see below.

Position Classification	Existing FTEs (enter year)	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
A. Direct Patient Care Positions	N/A			
RN Nights		4.33	$38.00	$27.35
RN Days		4.33	35.00	$27.35
Triage Nurse Nights		1.0	38.00	$27.35
Triage Nurse Days		1.0	35.00	$27.35
Radiology tech/CT Tech		4.20	28.75	$32.00
CT Tech		4.20	32.50	$32.00
Lab Tech		4.33	29.50	$28.45
Ultrasound Tech		4.20	33.75	$28.55
Total Direct Patient Care Positions		27.59		
B. Non-Patient Care Positions	N/A			
Director/Administrator		1.0	$52.00	
Receptionist/Unit Secretary		4.20	15.20	$13.85
Additional Front Desk >30 Patients/Day		1.0	15.00	$13.85
Total Non-Patient Care Positions		6.20		
Total Employees *(A+B)*		33.79		
C. Contractual Staff		13.00	14.00	
Total Staff *(A+B+C)*		46.79		

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

   A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

   Response: There are no less costly, more effective or more efficient alternative methods of providing the benefits that will be provided by a new FSED in the applicant's service area. While the applicant could add treatment room capacity at the hospital

without a CON, there is no existing space within the footprint of the hospital to do so. Therefore, any addition to the ED at SFH-Bartlett would require major construction, cost more and be extremely disruptive to patients, family members and staff.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response: The FSED will be located in a new building, approximately 10 miles away from SFH-Bartlett. There is no alternative to new construction. Expansion of the existing ED department at the hospital will not provide the significant benefits to the proposed service area patients that locating necessary emergency services closer to these patients will provide.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

   Response: SFH-Bartlett works with many of the area providers in the services it provides on its main campus. These relationships are expected to continue. In addition, with the increased availability of emergency services to some of the outlying communities, SFH-Bartlett expects to expand these relationships.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   A. Positive Effects

   Response: SFH-Bartlett is planning for a time period a few years out, as its utilization increases on its main campus for emergency services. With the inability to expand emergency services on its existing campus without major construction and significant disruption to patients, family members, and staff, an FSED is a viable option to provide increased capacity for ED services. Locating them 10 miles away from SFH-Bartlett also allows for increased access to these services by patients who might otherwise have to travel farther to receive these services and/or it provides a viable option and allows for patient choice for these services.

   B. Negative Effects

   Response: The project should not have any significant adverse effects on area providers. SFH-Bartlett is the closest hospital to the service area, and has located the FSED far enough away to provide increased access for significant portions of the service area. SFH-Bartlett estimates that 20 to 25% of the patients for this FSED will be a patient population it already serves who will choose to receive these emergency services closer to home.

3. A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response: SFH-Bartlett and its proposed FSED are part of the larger Tenet system. As such, Tenet has both the necessary expertise and financial and other resources to ensure that appropriate and adequate professional staff will be available. The applicant does not anticipate any difficulties with recruiting qualified and competent staff for the FSED.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response: The FSED will be a part of SFH-Bartlett, which is a licensed acute care hospital. Thus, the applicant is familiar with all licensing and certification requirements.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: Applicant has a number of affiliation agreements in place with different universities, colleges, and educational institutions and engages in the training of students in a number of disciplines including: emergency medicine, nursing, social work, pharmacy, nuclear medicine, diagnostic medical sonography, respiratory therapy, occupational therapy, and other disciplines. A representative sample of the educational institutions the applicant works with includes:

1. Austin Peay State University
2. Baptist Memorial College of Health Sciences
3. Chamberlain College of Nursing
4. Concorde Career College
5. Drexel University
6. Dyersburg State Community College
7. East Tennessee State University
8. National College of Business & Technology
9. Notre Dame College
10. Saint Louis University
11. Southwest Tennessee Community College
12. Tennessee State University
13. Tennessee Technological University
14. Union University
15. University of Memphis
16. University of Tennessee
17. Vanderbilt University

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if

applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure:

Response: The applicant is licensed by the State of Tennessee, Department of Health, Board for Licensing Health Care Facilities.

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

Response: The applicant is both Medicare and TennCare certified.

Accreditation (i.e., Joint Commission, CARF, etc.):

Response: The applicant is accredited by The Joint Commission.

A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Response: Please see copy of the current hospital license and The Joint Commission accreditation included as Attachment Section C, Contribution to the Orderly Development of Health Care-4A.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: Please see copy of the letter from the Department of Health included as Attachment Contribution to the Orderly Development of Health Care-4B.

C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Response: N/A

1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response: N/A

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

A. Has any of the following:

1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response: None.

2) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Response: None.

3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response: None.

B. Been subjected to any of the following:

1) Final Order or Judgment in a state licensure action;

Response: None.

2) Criminal fines in cases involving a Federal or State health care offense;

Response: None.

3) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: None.

4) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: None.

5) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: None.

6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: None.

7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: None.

8) Is presently subject to a corporate integrity agreement.

Response: None.

6. Outstanding Projects:

A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	Project Name	Date Approved	*Annual Progress Report(s)		Expiration Date
			Due Date	Date Filed	

*Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response: N/A

B. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: N/A

7. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

A. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? yes

Response: The applicant has a CT scanner and an MRI.

B. If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?

Response: The applicant received final confirmation of its submission on April 1, 2016 from Alecia Craighead of the HSDA.

C. If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission?

Response: The applicant received final confirmation of its submission on April 1, 2016 from Alecia Craighead of the HSDA.

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The applicant will report annually on appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

   Response: The FSED will improve the health of the people of Tennessee by allowing them to receive important emergency services - and the ability to seek treatment for such services before their condition worsens.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

   Response: Locating an FSED closer to much of the patient population will allow the service area residents to have increased access to emergency services which will enable them to achieve better health.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

   Response: The FSED will both address the health of Tennesseans in the service area while costing less to build and with less disruption to patients, family members, and staff than expanding the SFH-Bartlett ED.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response: The applicant is licensed and fully accredited by the Joint Commission.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

   Response: The applicant will ensure that the staff hired for this project will be appropriate, qualified staff. The applicant plans to staff the FSED in the same manner in which it staffs the hospital ED, including using board certified or board eligible emergency physicians.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Please see proof of publication showing that publication occurred in the Commercial Appeal on January 10, 2017.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Response: N/A

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**
   Response: N/A.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		4/2017
2. Architectural and engineering contract signed		4/2017
3. Construction documents approved by the Tennessee Department of Health		8/2017
4. Construction contract signed		9/2017
5. Building permit secured		10/2017
6. Site preparation completed		12/2017
7. Building construction commenced		12/2017
8. Construction 40% complete		4/2018
9. Construction 80% complete		8/2018
10. Construction 100% complete (approved for occupancy		10/2018
11. *Issuance of License		
12. *Issuance of Service		
13. Final Architectural Certification of Payment		11/2018
14. Final Project Report Form submitted (Form HR0055)		1/2019

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

Attachment Section A-4A

Organizational Documents
Organizational Chart

Saint Francis Hospital-Bartlett, Inc.

Saint Francis Hospital-Bartlett, Inc.
1445 Ross Ave., Suite 1400
Dallas, Texas 75202
EIN: 75-2804737

↑

Tenet HealthSystem Medical, Inc.
1445 Ross Ave., Suite 1400
Dallas, Texas 75202
EIN: 95-2111054
100% Owner of Saint Francis Hospital-Bartlett, Inc.

↑

Healthcare Network Holdings, Inc.
1445 Ross Ave., Suite 1400
Dallas, Texas 75202
EIN: 13-3527632
100% Owner of Tenet HealthSystem Medical, Inc.

↑

Tenet Healthcare Corporation
1445 Ross Ave., Suite 1400
Dallas, Texas 75202
EIN: 95-2557091
100% Owner of Healthcare Network Holdings, Inc.

Tenet Healthcare Corporation is a publicly traded corporation

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

WALLER LANSDEN DORTCH
STE 2700
511 UNION ST
NASHVILLE, TN 37219-1791

Request Type: Certified Copies
Request #: 225172

Issuance Date: 01/06/2017
Copies Requested: 1

Document Receipt

Receipt # : 003036265 Filing Fee: $20.00

Payment-Check/MO - WALLER LANSDEN DORTCH, NASHVILLE, TN $20.00

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that **Saint Francis Hospital - Bartlett, Inc.**, Control # 364564 was formed or qualified to do business in the State of Tennessee on 01/25/1999. Saint Francis Hospital - Bartlett, Inc. has a home jurisdiction of TENNESSEE and is currently in an Active status. The attached documents are true and correct copies and were filed in this office on the date(s) indicated below.

Tre Hargett
Secretary of State

Processed By: Nichole Hambrick

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
3614-2208	01/25/1999	Initial Filing
3900-0498	05/02/2000	2000 Annual Report (Due 05/01/2000)
4175-1570	04/10/2001	2001 Annual Report (Due 05/01/2001)
4490-0517	04/25/2002	2002 Annual Report (Due 05/01/2002)
4795-2066	04/21/2003	2003 Annual Report (Due 05/01/2003)
4912-0917	09/19/2003	Assumed Name
5027-2121	02/05/2004	2004 Annual Report (Due 05/01/2004)
5243-0482	09/27/2004	Registered Agent Change (by Agent)
5391-3285	03/16/2005	2005 Annual Report (Due 05/01/2005)
5666-1704	01/30/2006	2005 Annual Report (Due 04/01/2006)
5990-1173	03/21/2007	2006 Annual Report (Due 04/01/2007)
6223-1584	02/27/2008	2007 Annual Report (Due 04/01/2008)
6461-0063	03/02/2009	2008 Annual Report (Due 04/01/2009)
6635-2878	12/28/2009	Assumed Name

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
6664-3213	03/05/2010	2009 Annual Report (Due 04/01/2010)
6809-2202	01/07/2011	2010 Annual Report (Due 04/01/2011)
6833-0207	02/15/2011	Assumed Name
7010-2940	03/09/2012	2011 Annual Report (Due 04/01/2012)
7154-1742	02/26/2013	2012 Annual Report (Due 04/01/2013)
7246-0204	09/30/2013	Assumed Name
7314-2349	03/27/2014	2013 Annual Report (Due 04/01/2014)
7337-2728	05/02/2014	Assumed Name Cancellation
7337-2729	05/02/2014	Articles of Amendment
B0077-5732	04/02/2015	2014 Annual Report (Due 04/01/2015)
B0210-2887	03/21/2016	2015 Annual Report (Due 04/01/2016)

CHARTER
OF

Tenet HealthSystem Bartlett, Inc.

The undersigned person(s) under the Tennessee Business Corporation Act adopt(s) the following charter for the above listed corporation:

1. The name of the corporation is Tenet HealthSystem Bartlett, Inc.

[**NOTE:** Pursuant to Tennessee Code Annotated Section 48-14-101(a)(1), each corporation name must contain the word "corporation", "incorporated", or "company" or the abbreviation "corp", "inc.", or "co.".]

2. The number of shares of stock the corporation is authorized to issue is

1,000 Common Shares with a Par Value of $1.00

3. (a) The complete address of the corporation's initial registered office in Tennessee is c/o C T CORPORATION SYSTEM, 530 Gay Street Knoxville, Tennessee 37902

Street Address City State, Zip Code

County of KNOX.

[**NOTE:** A street address, a zip code and the county are required by Tennessee Code Annotated Section 48-12-102(a)(3).]

(b) The name of the initial registered agent, to be located at the address listed in 3(a), is

C T CORPORATION SYSTEM

4. The name and complete address of each incorporator is:

Mary H. Yumibe 3820 State Street, Santa Barbara, CA 93105

Name Address Zip Code

Name Address Zip Code

Name Address Zip Code

[**NOTE:** An address and zip code are both required by Tennessee Code Annotated Section 48-12-102 (a)(4).]

5. The complete addresses of the corporation's principal office is:

3820 State Street, Santa Barbara, CA 93105

Street Address City State/Country Zip Code

[**NOTE:** A street address and a zip code are both required by Tennessee Code Annotated Section 48-12-102 (a)(5).]

6. The corporation is for profit.

7. Other provisions:

[**NOTE:** Insert here any provision(s) desired and permitted by law. **Examples:** names and addresses of persons serving are the initial board of directors, business purpose(s) of the corporation, management or regulation of affairs of the corporation, provision limiting the personal liability of directors for monetary damages for breach of fiduciary duty, etc. See Tennessee Code Annotated Section 48-12-102(b).]

January 20, 1999
Signature Date

Mary H. Yumibe
Incorporator's Signature

Mary H. Yumibe
Incorporator's Name (typed or printed)

CORPORATION ANNUAL REPORT
STATE OF TENNESSEE
SECRETARY OF STATE
SUITE 1800, JAMES K. POLK BUILDING
NASHVILLE, TN. 37243-0306

AMOUNT DUE - $20.00

CURRENT FISCAL YEAR CLOSING MONTH: 01 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 05/01/00

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564 OR FEDERAL EMPLOYER IDENTIFICATION NUMBER:

NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.
3820 STATE ST
SANTA BARBARA, CA 93105

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
3820 STATE ST, SANTA BARBARA, CA 93105
B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

*** * BLOCKS 4A AND 4B MUST BE COMPLETED OR THE ANNUAL REPORT WILL BE RETURNED * ***

(4) A. NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen E. Campbell	3820 State Street. Samta Barbara,	CA 93105
SECRETARY	Richard B. Silver	3820 State Street, Santa Barbara,	CA 93105

B. BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Richard B. Silver	3820 State Street. Santa Barbara,	CA 93105

(5) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

(6) INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.
(BLOCK 5A AND/OR 5B.) THERE IS AN ADDITIONAL $20.00 REQUIRED FOR CHANGES MADE TO THIS INFORMATION.

A. CHANGE OF REGISTERED AGENT:

B. CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

RECEIVED
00 MAY -2 AM 8:45
SECRETARY OF STATE

(7) A. THIS BOX APPLIES **ONLY** TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: **IF BLANK OR CHANGE, PLEASE CHECK APPROPRIATE BOX:** ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX UNLESS OTHERWISE INDICATED. ☐ RELIGIOUS

(8) SIGNATURE

(9) DATE
April 12, 2000

(10) TYPE PRINT NAME OF SIGNER:
Richard B. Silver

(11) TITLE OF SIGNER
Secretary

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CORPORATION ANNUAL REPORT

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Ave. N, 6th Floor
William R. Snodgrass Tower
Nashville, TN. 37243

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office, or
$40, if any changes are made in block #6 to the registered agent/office

CURRENT FISCAL YEAR CLOSING MONTH: 01 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 05/01/01

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564

(2A) NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.
3820 STATE ST
SANTA BARBARA, CA 93105

D 01/25/1999 FOR PROFIT

(2B) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
3820 STATE ST, SANTA BARBARA, CA 93105

B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen E. Corbeil	13737 Noel Road	Dallas, TX 75240
SECRETARY	Richard B. Silver	3820 State Street	Santa Barbara, CA 93105

(5) BOARD OF DIRECTORS (NAMES BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Richard B. Silver	3820 State Street, Santa Barbara, CA 93105	

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I). CHANGE OF REGISTERED AGENT:

(II). CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

(7) A. THIS BOX APPLIES **ONLY** TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: **IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX:** ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK. ☐ RELIGIOUS

(8) SIGNATURE

(9) DATE 4/3/01

(10) TYPE PRINT NAME OF SIGNER: Richard B. Silver

(11) TITLE OF SIGNER Secretary

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CONTINUED ON BACK

CORPORATION ANNUAL REPORT

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Ave. N, 6th Floor
William R. Snodgrass Tower
Nashville, TN. 37243

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office, or
$40, if any changes are made in block #6 to the registered agent/office

CURRENT FISCAL YEAR CLOSING MONTH: 01 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 05/01/02

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.
3820 STATE ST
SANTA BARBARA, CA 93105

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
3820 STATE ST, SANTA BARBARA, CA 93105

B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen E. Corbeil	13737 Noel Road, Dallas, TX	75240
SECRETARY	Richard B. Silver	3820 State Street, Santa Barbara, CA	93105

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Richard B. Silver	3820 State Street, Santa Barbara, CA	93105

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I). CHANGE OF REGISTERED AGENT:

(II). CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX: ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK. ☐ RELIGIOUS

(8) SIGNATURE

(9) DATE 4/15/02

(10) TYPE PRINT NAME OF SIGNER: Richard B. Silver

(11) TITLE OF SIGNER Secretary

* * THIS REPORT MUST BE DATED AND SIGNED * *

RECEIVED 2002 APR 26 SECRETARY OF STATE

CORPORATION ANNUAL REPORT

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Ave. N, 6th Floor
William R. Snodgrass Tower
Nashville, TN. 37243

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office, or
$40, if any changes are made in block #6 to the registered agent/office

CURRENT FISCAL YEAR CLOSING MONTH: 01 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 05/01/03

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.
3820 STATE ST
SANTA BARBARA, CA 93105

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

RILEY DARNELL
SECRETARY OF STATE
APR 21 AM 10: 15
FILED
TENNESSEE

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
3820 STATE ST, SANTA BARBARA, CA 93105

B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen E. Corbeil	7733 Forsyth Blvd.	St. Louis, MO 63105
SECRETARY	Richard B. Silver	3820 State Street	Santa Barbara, CA 93105
Treasurer	Dennis L. Dent	3820 State Street	Santa Barbara, CA 93105

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Richard B. Silver	3820 State Street	Santa Barbara, CA 93105

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I). CHANGE OF REGISTERED AGENT:

(II). CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

(7) A. THIS BOX APPLIES **ONLY** TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: **IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX:** ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK. ☐ RELIGIOUS

(8) SIGNATURE

(9) DATE 4/1/03

(10) TYPE PRINT NAME OF SIGNER: Richard B. Silver

(11) TITLE OF SIGNER Secretary

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only
RECEIVED
STATE OF TENNESSEE
2003 SEP 19 PM 12: 07
RILEY DARNELL
SECRETARY OF STATE

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Tenet HealthSystem Bartlett, Inc.

2. The state or country of incorporation is Tennessee.

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is
Saint Francis Hospital-Bartlett.

[**NOTE:** The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

September 16, 2003
Signature Date

Tenet HealthSystem Bartlett, Inc.
Name of Corporation

Vice President
Signer's Capacity

Signature

Lawrence G. Hixon
Name (typed or printed)

SS-4402 (Rev. 4/01)

Filing Fee: $20

RDA1720

CORPORATION ANNUAL REPORT

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Ave. N, 6th Floor
William R. Snodgrass Tower
Nashville, TN. 37243

Annual Report Filing Fee Due:
$20, If no changes are made in block #6 to the registered agent/office, or
$40, If any changes are made in block #6 to the registered agent/office

CURRENT FISCAL YEAR CLOSING MONTH: 01 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 05/01/04

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.
3820 STATE ST
SANTA BARBARA, CA 93105

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

04 FEB -5 PM 12:58
SECRETARY OF STATE

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
3820 STATE ST, SANTA BARBARA, CA 93105

B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen Corbeill	3820 State Street, Santa Barbara, CA 93105	
SECRETARY	Caitlin M. Larsen	3820 State Street, Santa Barbara, CA 93105	

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Caitlin M. Larsen	3820 State Street, Santa Barbara, CA 93105	

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
530 GAY ST, KNOXVILLE, TN 37902

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I). CHANGE OF REGISTERED AGENT: _____

(II). CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX: ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK. ☐ RELIGIOUS

(8) SIGNATURE Kristina A. Mack

(9) DATE 2/2/04

(10) TYPE PRINT NAME OF SIGNER: Kristina A. Mack

(11) TITLE OF SIGNER Asst. Secretary

** THIS REPORT MUST BE DATED AND SIGNED **

CONTINUED ON BACK

SECRETARY OF STATE
DIVISION OF BUSINESS SERVICES
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

RECEIVED STATE OF TENNESSEE 2004 SEP 27 AM 8:00 FILED SECRETARY OF STATE

MASS CHANGE OF REGISTERED OFFICE (BY AGENT)

Pursuant to the provisions of Sections 48-15-102 and 48-25-108 of the Tennessee Business Corporation Act, Sections 48-55-102 and 48-65-108 of the Tennessee Nonprofit Corporation Act, Section 48-208-102 of the Tennessee Limited Liability Company Act, Sections 61-2-104 and 61-2-904 of the Tennessee Revised Uniform Limited Partnership Act, and Section 61-1-144 of the Tennessee Uniform Limited Partnership Act, the undersigned registered agent hereby submits this application to change its business address and the registered office address of the businesses noted below:

1. **The names of the affected corporations, limited liability companies, limited partnerships and limited liability partnerships are identified in the attached list by their S.O.S. control numbers, which list is incorporated herein by reference.**

2. **The street address of its current registered office of record is 530 Gay Street, Knoxville, TN 37902.**

3. **The name of the current registered agent is C T CORPORATION SYSTEM.**

4. **The street address (including county) of the new registered office is:**

   800 S. Gay Street, Suite 2021, Knoxville, TN 37929-9710 (Knox)

5. **After the change, the street addresses of the registered office and the business office of the registered agent will be identical.**

6. **The corporations, limited liability companies, limited partnerships and limited liability partnerships identified in the attached list, and which are companies active on the records of C T Corporation System, have been notified of the change of address for the registered office.**

7. **The change submitted for the business entities for which C T Corporation System does not provide active statutory representation services is filed for State administrative purposes using information provided by the State. C T Corporation System disclaims knowledge of, and responsibility for, any companies for which C T Corporation System does not provide active services.**

9/27/04
Signature Date

Signature of Registered Agent

Kenneth J. Uva, Vice President
Printed or Typed Name

CORPORATION ANNUAL REPORT

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office
$40, if any changes are made in block #6 to the registered agent/office

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Ave. N, 6th Floor
William R. Snodgrass Tower
Nashville, TN. 37243

CURRENT FISCAL YEAR CLOSING MONTH 01 IF DIFFERENT, CORRECT MONTH IS 12

THIS REPORT IS DUE ON OR BEFORE 05/01/05

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.
3820 STATE ST
SANTA BARBARA, CA 93105

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:
Attn: Law Dept.
13737 Noel Road
Dallas, TX 75240

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
3820 STATE ST, SANTA BARBARA, CA 93105

B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4
13737 Noel Road	Dallas	TX	75240-7367

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen E. Corbeil	13737 Noel Road	Dallas, TX 75240-7367
SECRETARY	Caitlin M. Larsen	13737 Noel Road	Dallas, TX 75240-7367
Treasurer	Dennis L. Dent	3820 State Street	Sanca Barbara, CA 93105

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS (INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Caitlin M. Larsen	13737 Noel Road	Dallas, TX 75240-7367

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I). CHANGE OF REGISTERED AGENT:

(II). CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

(7) A. THIS BOX APPLIES **ONLY** TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: **IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX:** ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK. ☐ RELIGIOUS

(8) SIGNATURE Kristina A. Mack

(9) DATE 2/20/05

(10) TYPE PRINT NAME OF SIGNER: Kristina A. Mack

(11) TITLE OF SIGNER Asst. Secretary

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CONTINUED ON BACK

CORPORATION ANNUAL REPORT

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Ave. N, 6th Floor
William R. Snodgrass Tower
Nashville, TN. 37243

38

Annual Report Filing Fee Due:
$20, If no changes are made in block #6 to the registered agent/office, or
$40, If any changes are made in block #6 to the registered agent/office

CURRENT FISCAL YEAR CLOSING MONTH: 12 IF DIFFERENT, CORRECT MONTH IS _____

THIS REPORT IS DUE ON OR BEFORE 04/01/06

(1) SECRETARY OF STATE CONTROL NUMBER: 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION:

TENET HEALTHSYSTEM BARTLETT, INC.

ATTN LAW DEPT. DONNA JARRELL
13737 NOEL ROAD
DALLAS, TX 75240

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION:
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

5666.1704

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
13737 NOEL ROAD, DALLAS, TX 75240-7367

B. CHANGE OF PRINCIPAL ADDRESS:

STREET	CITY	STATE	ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

TITLE	NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
PRESIDENT	Stephen E. Corbeil	15450 South Outer Forty Dr. Ste 120	Chesterfield MO 63017
SECRETARY	Caitlin Larsen	13737 Noel Rd Ste 100	Dallas TX 75240
Treasurer	Jeffrey S. Sherman	13737 Noel Rd Ste 100	Dallas TX 75240

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE). (ATTACH ADDITIONAL SHEET IF NECESSARY.) ☐ SAME AS ABOVE ☐ NONE

OR LISTED BELOW: NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
Caitlin Larsen	13737 Noel Rd Ste 100	Dallas TX 75240

RECEIVED
2006 JAN 30 PM 1:11
SECRETARY OF STATE

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(I). CHANGE OF REGISTERED AGENT:

(II). CHANGE OF REGISTERED OFFICE:

STREET	CITY	STATE	ZIP CODE + 4	COUNTY
		TN		

(7) A. THIS BOX APPLIES **ONLY** TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED: **IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX:** ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK. ☐ RELIGIOUS

(8) SIGNATURE Caitlin Larsen

(9) DATE 1/20/2006

(10) TYPE PRINT NAME OF SIGNER: Caitlin Larsen

(11) TITLE OF SIGNER Sec/Dir

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

CONTINUED ON BACK

CORPORATION ANNUAL REPORT

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office, or
$40, if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

38

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/07

(1) SECRETARY OF STATE CONTROL Number: 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION

TENET HEALTHSYSTEM BARTLETT, INC.

%LAW DEPT-D JARRELL
13737 NOEL ROAD
DALLAS, TX 75240

D 01/25/1999 FOR PROFIT

(2B.) STATE OR COUNTRY OF INCORPORATION
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

RECEIVED STATE OF TENNESSEE 2007 MAR 20 AM 11:53 RILEY DARNELL SECRETARY OF STATE

5990.0903

5990.1173

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
13737 NOEL ROAD, DALLAS, TX 75240-7367
B. CHANGE OF PRINCIPAL ADDRESS:
STREET CITY STATE ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

Title	Name	Business Address	City, State, Zip Code + 4
President	Stephen E. Corbeil	15450 S Outer Forty Dr	Ste 120 Chesterfield Mo 63017
Secretary	Caitlin Larsen	13737 Noel Rd Ste 100	Dallas TX 75240
Treasurer	Jeffrey S. Sherman	13737 Noel Rd Ste 100	Dallas TX 75240

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE.) (ATTACH ADDITIONAL SHEET IF NECESSARY.)
☐ SAME AS ABOVE, ☐ NONE, OR LISTED BELOW:

Name	Business Address	City, State, Zip Code + 4
Caitlin Larsen	13737 Noel Rd Ste 100	Dallas TX 75240

RECEIVED STATE OF TENNESSEE 2007 MAR 21 AM 9:50 RILEY DARNELL SECRETARY OF STATE

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): _____

(City) _____ (State) TN (Zip Code + 4) _____ (County) _____

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED:
IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX: ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK ☐ RELIGIOUS

(8) SIGNATURE Caitlin Larsen

(9) DATE

(10) TYPE/PRINT NAME OF SIGNER

Caitlin Larsen, Sec/Dir 2/6/07 469-893-2701

** THIS REPORT MUST BE D/

SS-4444 (Rev. 11-05) INSTRUCTIONS: www.state.tn.us/sos/ or 615-741-2286 RDA 1678

12

CORPORATION ANNUAL REPORT

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office, or
$40, if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/08

(1) SECRETARY OF STATE CONTROL Number. 0364564

(2A.) NAME AND MAILING ADDRESS OF CORPORATION

TENET HEALTHSYSTEM BARTLETT, INC.

%LAW DEPT-D JARRELL
13737 NOEL ROAD
DALLAS, TX 75240

(2B.) STATE OR COUNTRY OF INCORPORATION
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
13737 NOEL ROAD, DALLAS, TX 75240-7367

B. CHANGE OF PRINCIPAL ADDRESS:
STREET CITY STATE ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS.
(ATTACH ADDITIONAL SHEET IF NECESSARY.)

Title	Name	Business Address	City, State, Zip Code + 4
President	John Holland	13737 Noel Rd Ste 100	Dallas TX 75240
Secretary	Caitlin Larsen	13737 Noel Rd Ste 100	Dallas TX 75240
Treasurer	Jeffery S Sherman	13737 Noel Rd Ste 100	Dallas TX 75240

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE.) (ATTACH ADDITIONAL SHEET IF NECESSARY.)
☐ SAME AS ABOVE, ☒ NONE, OR LISTED BELOW:

Name	Business Address	City, State, Zip Code + 4
Caitlin Larsen	13737 Noel Rd Ste 100	Dallas TX 75240

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): _____

(City) _____ (State) TN (Zip Code + 4) _____ (County) _____

RECEIVED
STATE OF TENNESSEE
2008 FEB 27 PM 3:
SECRETARY OF STATE

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED:
IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX. ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK ☐ RELIGIOUS

(8) SIGNATURE Caitlin Larsen

(9) DATE 1/15/08

(10) TYPE/PRINT NAME OF SIGNER Caitlin Larsen

(11) TITLE OF SIGNER Sec/Dir

*** * THIS REPORT MUST BE DATED AND SIGNED * ***

SS-4444 (Rev. 11-05) INSTRUCTIONS: www.state.tn.us/sos/ or 615-741-2286 RDA 1678

6223.1584

38

6461.0063

CORPORATION ANNUAL REPORT

Annual Report Filing Fee Due:
$20, if no changes are made in block #6 to the registered agent/office, or
$40, if any changes are made in block #6 to the registered agent/office.

Please return completed form to:
TENNESSEE SECRETARY OF STATE
Attn: Annual Report
312 Eighth Avenue N. 6th Floor
William R. Snodgrass Tower
Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12

THIS REPORT IS DUE ON OR BEFORE: 04/01/09

(1) SECRETARY OF STATE CONTROL Number: 0364564

(2A) NAME AND MAILING ADDRESS OF CORPORATION

TENET HEALTHSYSTEM BARTLETT, INC.

%LAW DEPT-D JARRELL
13737 NOEL ROAD
DALLAS, TX 75240

(2B) STATE OR COUNTRY OF INCORPORATION
TENNESSEE

(2C) ADD OR CHANGE MAILING ADDRESS:

STATE OF TENNESSEE
2009 MAR -2 PM 12:07
SECRETARY OF STATE

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE
13737 NOEL ROAD, DALLAS, TX 75240-7367

B. CHANGE OF PRINCIPAL ADDRESS
STREET CITY STATE ZIP CODE + 4

(4) NAME AND BUSINESS ADDRESS, INCLUDING ZIP CODE, OF THE PRESIDENT, SECRETARY AND OTHER PRINCIPAL OFFICERS.
(ATTACH ADDITIONAL SHEET IF NECESSARY.)

Title	Name	Business Address	City, State, Zip Code + 4
President	JOHN HOLLAND	13737 NOEL RD STE 100	DALLAS TX 75240
Secretary	KRISTINA A. MACK	13737 NOEL RD STE 100	DALLAS TX 75240
TREAS	JEFFREY S. SHERMAN	13737 NOEL RD STE 100	DALLAS TX 75240

(5) BOARD OF DIRECTORS (NAMES, BUSINESS ADDRESS INCLUDING ZIP CODE) (ATTACH ADDITIONAL SHEET IF NECESSARY.)
☐ SAME AS ABOVE. ☐ NONE, OR LISTED BELOW:

Name	Business Address	City, State, Zip Code + 4
KRISTINA A. MACK	13737 NOEL RD STE 100	DALLAS TX 75240

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
C T CORPORATION SYSTEM
B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
800 S. GAY STREET, SUITE 2021, KNOXVILLE, TN 37929-9710
C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i) CHANGE OF REGISTERED AGENT: _____

(ii) CHANGE OF REGISTERED OFFICE (Street Address): _____

(City) _____ (State) TN (Zip Code + 4) _____ (County) _____

(7) A. THIS BOX APPLIES ONLY TO NONPROFIT CORPORATIONS. OUR RECORDS REFLECT THAT YOUR NONPROFIT CORPORATION IS A PUBLIC BENEFIT OR A MUTUAL BENEFIT CORPORATION AS INDICATED:
IF BLANK OR INCORRECT, PLEASE CHECK APPROPRIATE BOX: ☐ PUBLIC ☐ MUTUAL

B. IF A TENNESSEE RELIGIOUS CORPORATION, PLEASE CHECK BOX IF BLANK ☐ RELIGIOUS

(8) SIGNATURE
Kristina A. Mack

(9) DATE
1/21/09

(10) TYPE/PRINT NAME OF SIGNER
KRISTINA A. MACK

(11) TITLE OF SIGNER
SEC/DIR

* * THIS REPORT MUST BE DATED AND SIGNED * *

SS-4444 (Rev. 11-05)

INSTRUCTIONS: www.state.tn.us/sos/ or 615-741-2286

RDA 1676

38

2009 JAN 13 PM 3:51

2009 DEC 28 AM 11:21

For Office Use Only

SECRETARY OF STATE

6635.2878

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Tenet HealthSystem Bartlett, Inc.

2. The state or country of incorporation is Tennessee.

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is
Saint Francis Hospital - Bartlett.

[**NOTE:** The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

December 18, 2009
Signature Date

Tenet HealthSystem Bartlett, Inc.
Name of Corporation

Secretary
Signer's Capacity

Kristina A. Mack
Signature

Kristina A. Mack
Name (typed or printed)

SS-4402 (Rev. 4/01) Filing Fee: $20 RDA1720

38

Tennessee Corporation Annual Report Form

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2010

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Please return completed form to:
Tennessee Secretary of State
Attn: Annual Reports
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243
Phone: (615) 741-2286

6664.3213

SOS Control Number: 364564
Corporation For-Profit - Domestic Date Formed: 01/25/1999 Formation Locale: Tennessee

Name and Mailing Address:
TENET HEALTHSYSTEM BARTLETT, INC.
%LAW DEPT-D JARRELL
13737 NOEL ROAD
DALLAS, TX 752400000 USA

(1) Add or Change Mailing Address:
ATTN: LAW DEPT
1445 ROSS AVE STE 1400
DALLAS TX 75202

Principal Office Address:
13737 NOEL ROAD
DALLAS, TX 752407367 USA

(2) Change Principal Office Address:
1445 ROSS AVE STE 1400
DALLAS TX 75202

Registered Agent (RA) and Registered Office (RO) Address:
CT CORPORATION SYSTEM
800 S GAY ST
STE 2021
KNOXVILLE, TN 37929 USA

(3) Change RA and/or RO Address ($20 fee):

RECEIVED
STATE OF TENNESSEE
2010 MAR -5 P 3:32
THE HARWELL BUILDING
SECRETARY OF STATE

Note: The Registered Office address must be a physical Tennessee address (no postal box).

(4) Name and business address (with zip code) of the President, Secretary and other principal officers. Attach additional sheet if necessary.

Title	Name	Business Address	City, State, Zip
PRESIDENT	KEM MULLINS	1445 ROSS AVE STE 1400	DALLAS TX 75202
TREASURER	TYLER MURPHY	1445 ROSS AVE STE 1400	DALLAS TX 75202
SECRETARY	KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202

(5) Board of Directors names and business address (with zip code). Attach additional sheet if necessary.
___ Same as above officers, ___ none, or listed below

Name	Business Address	City, State, Zip
KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202

(6) This section applies to non-profit corporations ONLY.
A. Our records reflect that your non-profit corporation is a public benefit or a mutual benefit corporation as indicated.
If blank or incorrect, please check appropriately: ___Public ___Mutual
B. If a Tennessee religious corporation, please check here if blank: ___Religious

(7) Signature: Kristina A. Mack (8) Date: 2/17/10

(9) Type/Print Name: KRISTINA A. MACK (10) Title: SEC/DIR

Instructions: Legibly complete the form above. Enclose a check made payable to the Tennessee Secretary of State. Sign and date this form and return to the address provided above. Additional instructions at http://tn.gov/sos/bus_srv/annual_reports.htm

SS-4444 RDA 1678

38

Tennessee Corporation Annual Report Form

AR Filing #: 02427890
Status: Unsubmitted

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2011 Reporting Year: 2010

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Please return completed form to:
Tennessee Secretary of State
Attn: Annual Reports
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
Phone: (615) 741-2286

6809.2202

SOS Control Number: 364564
Corporation For-Profit - Domestic Date Formed: 01/25/1999 Formation Locale: Tennessee

(1) Name and Mailing Address:
TENET HEALTHSYSTEM BARTLETT, INC.
ATTN: LAW DEPT
1445 ROSS AVE
STE 1400
DALLAS, TX 75202 USA

(2) Principal Office Address:
1445 ROSS AVE
STE 1400
DALLAS, TX 75202 USA

(3) Registered Agent (RA) and Registered Office (RO) Address: Agent Changed: No
CT Corporation System
800 S Gay Street
Suite 2021
Knoxville, TN 37929 USA

(4) Name and business address (with zip code) of the President, Secretary and other principal officers.

Title	Name	Business Address	City, State, Zip
TREASURER	TYLER MURPHY	1445 ROSS AVE STE 1400	DALLAS, TX 75202
PRESIDENT	KEM MULLINS	1445 ROSS AVE STE 1400,	DALLAS TX 75202
SECRETARY	KRISTINA A. MACK	1445 ROSS AVE STE 1400,	DALLAS TX 75202

(5) Board of Directors names and business address (with zip code). (___ None)

Name	Business Address	City, State, Zip
KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS, TX 75202

(6) This section applies to non-profit corporations ONLY.
A. Our records reflect that your non-profit corporation is a public benefit or a mutual benefit corporation as indicated.
If blank or incorrect, please check appropriately: ___Public ___Mutual
B. If a Tennessee religious corporation, please check here if blank: ___Religious

RECEIVED
STATE OF TENNESSEE
2011 JAN -7 AM 10: 10
TRE HARGETT
SECRETARY OF STATE

(7) Signature: Kristina A. Mack (8) Date: 1/4/11

(9) Type/Print Name: KRISTINA A. MACK (10) Title: SEC/DIR

Instructions: Legibly complete the form above. **Enclose a check made payable to the Tennessee Secretary of State in the amount of $20.00.** Sign and date this form and return to the address provided above. Additional instructions at http://tn.gov/sos/bus_srv/annual_reports.htm

SS-4444

RDA 1678

RECEIVED
STATE OF TENNESSEE

2011 FEB 15 PM 4:00

TRE HARGETT
SECRETARY OF STATE

JAN 12 '17 PM 3:51

38

6833.0207

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Tenet HealthSystem Bartlett, Inc.

2. The state or country of incorporation is Tennessee.

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is
Saint Francis Hospital - Bartlett Imaging Center.

[**NOTE:** The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

February 14, 2011
Signature Date

Tenet HealthSystem Bartlett, Inc.
Name of Corporation

Secretary
Signer's Capacity

Kristina A. Mack
Signature

Kristina A. Mack
Name (typed or printed)

SS-4402 (Rev. 4/01) Filing Fee: $20 RDA1720

Tennessee Corporation Annual Report Form

AR Filing #: 02928546
Status: Unsubmitted

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2012 Reporting Year: 2011

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Please return completed form to:
Tennessee Secretary of State
Attn: Annual Reports
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
Phone: (615) 741-2286

SOS Control Number: 364564
Corporation For-Profit - Domestic Date Formed: 01/25/1999 Formation Locale: TENNESSEE

(1) Name and Mailing Address:
TENET HEALTHSYSTEM BARTLETT, INC.
ATTN LAW DEPT
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(2) Principal Office Address:
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(3) Registered Agent (RA) and Registered Office (RO) Address: Agent Changed: No
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

(4) Name and business address (with zip code) of the President, Secretary and other principal officers.

Title	Name	Business Address	City, State, Zip
PRESIDENT	KEM MULLINS	1445 ROSS AVE STE 1400,	DALLAS TX 75202
SECRETARY	KRISTINA A. MACK	1445 ROSS AVE STE 1400,	DALLAS TX 75202
TREASURER	TYLER MURPHY	1445 ROSS AVE STE 1400	DALLAS, TX 75202

(5) Board of Directors names and business address (with zip code). (___ None)

Name	Business Address	City, State, Zip
KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS, TX 75202

(6) This section applies to non-profit corporations ONLY.
A. Our records reflect that your non-profit corporation is a public benefit or a mutual benefit corporation as indicated.
If blank or incorrect, please check appropriately: ___Public ___Mutual
B. If a Tennessee religious corporation, please check here if blank: ___Religious

(7) Signature: Kristina A. Mack (8) Date: 3/5/12

(9) Type/Print Name: Kristina A Mack (10) Title: Secretary

Instructions: Legibly complete the form above. **Enclose a check made payable to the Tennessee Secretary of State in the amount of $20.00.** Sign and date this form and return to the address provided above. Additional instructions at http://tn.gov/sos/bus_srv/annual_reports.htm

SS-4444 RDA 1678

Received by Tennessee Secretary of State Tre Hargett, 03/09/2012, 11:12:49, 7010.2940

38

38

Tennessee Corporation Annual Report Form

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2013 Reporting Year: 2012

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Please return completed form to:
Tennessee Secretary of State
Attn: Annual Reports
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
Phone: (615) 741-2286

SOS Control Number: 364564
Corporation For-Profit - Domestic Date Formed: 01/25/1999 Formation Locale: TENNESSEE

Name and Mailing Address:
TENET HEALTHSYSTEM BARTLETT, INC.
ATTN LAW DEPT
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(1) Add or Change Mailing Address:

Principal Office Address:
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(2) Change Principal Office Address:

Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710
KNOX COUNTY

(3) Change RA and/or RO Address ($20 fee):

Note: The Registered Office address must be a physical Tennessee address (no postal box).

(4) Name and business address (with zip code) of the President, Secretary and other principal officers. Attach additional sheet if necessary.

Title	Name	Business Address	City, State, Zip
PRES	JEREMY CLARK	1445 ROSS AVE STE 1400	DALLAS TX 75202
TRES	TYLER MURPHY	1445 ROSS AVE STE 1400	DALLAS TX 75202
SEC	KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202

(5) Board of Directors names and business address (with zip code). Attach additional sheet if necessary.
___ Same as above officers, ___ None, pursuant to T.C.A. §48-18-101(c), or listed below.

Name	Business Address	City, State, Zip
KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202

(6) This section applies to non-profit corporations ONLY.
A. Our records reflect that your non-profit corporation is a public benefit or a mutual benefit corporation as indicated. If blank or incorrect, please check appropriately: ___Public ___Mutual
B. If a Tennessee religious corporation, please check here if blank: ___Religious

(7) Signature: Kristina A. Mack (8) Date: 2/13/13

(9) Type/Print Name: KRISTINA A. MACK (10) Title: SEC/DIR

Instructions: Legibly complete the form above. Enclose a check made payable to the Tennessee Secretary of State. Sign and date this form and return to the address provided above. Additional instructions at http://tn.gov/sos/bus_srv/annual_reports.htm

SS-4444 RDA 1678

7154.1742, 02/26/2013, 11:14:45, Received by Tennessee Secretary of State Tre Hargett

7246.0204, 09/30/2013, 15:45:47, Received by Tennessee Secretary of State Tre Hargett

38

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Ave.
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Tenet HealthSystem Bartlett, Inc.

2. The state or country of incorporation is Tennessee.

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is Saint Francis Hospital – Bartlett, Interventional Pain Management.

[**NOTE:** The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

September 27, 2013
Signature Date

Tenet HealthSystem Bartlett, Inc.
Name of Corporation

Director and Assistant Secretary
Signer's Capacity

Jeffrey S. McFall
Signature

Jeffrey S. McFall
Name (typed or printed)

SS-4402 (Rev. 4/01)

Filing Fee: $20

RDA1720

38

Tennessee Corporation Annual Report Form

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2014 Reporting Year: 2013

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Return completed form within 30 days to:
Tennessee Secretary of State
Attn: Annual Reports
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
Phone: (615) 741-2286

SOS Control Number: 364564
Corporation For-Profit - Domestic Date Formed: 01/25/1999 Formation Locale: TENNESSEE

Name and Mailing Address:
TENET HEALTHSYSTEM BARTLETT, INC.
ATTN LAW DEPT
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(1) Add or Change Mailing Address:

Principal Office Address:
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(2) Change Principal Office Address:

Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710
KNOX COUNTY

(3) Change RA and/or RO Address ($20 fee):

Note: The Registered Office address must be a Tennessee address.

(4) Name and business address (with zip code) of the principal officers. Attach additional sheet if necessary.

Title	Name	Business Address	City, State, Zip
PRESIDENT	JEREMY CLARK	1445 ROSS AVE STE 1400	DALLAS TX 75202
SECRETARY	KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202
TREASURER	TYLER MURPHY	1445 ROSS AVE STE 1400	DALLAS TX 75202

(5) Board of Directors names and business address (with zip code). Attach additional sheet if necessary.

___ Same as above officers, ___ None, pursuant to T.C.A. §48-18-101(c), or listed below.

Name	Business Address	City, State, Zip
PAUL A. CASTANON	1445 ROSS AVE STE 1400	DALLAS TX 75202
JEFFREY S. McFALL	1445 ROSS AVE STE 1400	DALLAS TX 75202
JEFFREY M. PETERSON	1445 ROSS AVE STE 1400	DALLAS TX 75202

(6) Signature: Kristina A. Mack (7) Date: 3-26-14

(8) Type/Print Name: KRISTINA A. MACK (9) Title: SECRETARY

Instructions: Legibly complete the form above. **Enclose a check made payable to the Tennessee Secretary of State.** Sign and date this form and return to the address provided above.

SS-4444

RDA 1678

7314.2349, 03/27/2014, 13:19:31, Received by Tennessee Secretary of State Tre Hargett

38

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR CANCELLATION OF ASSUMED CORPORATE NAME

For Office Use Only

Pursuant to the provisions of Section 48-14-101(e) of the *Tennessee Business Corporation Act* or Section 48-54-101(e) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is: Tenet HealthSystem Barlett, Inc.

2. The state or country of incorporation is: Tennessee

3. The corporation intends to cease transacting business under an assumed corporate name by cancelling it.

4. The assumed corporate name to be cancelled is: Saint Francis Hospital - Bartlett

5/1/14
Signature Date

Secretary
Signer's Capacity

Tenet HealthSystem Bartlett, Inc.
Name of Corporation

Kristina A. Mack
Signature

Kristina A. Mack
Name (typed or printed)

SS-4405 (Rev. 6/00)

RDA 1678

7337.2728, 05/02/2014, 10:24:08, Received by Tennessee Secretary of State Tre Hargett

38

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Ave.
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

ARTICLES OF AMENDMENT TO THE CHARTER (For-Profit)

For Office Use Only

CORPORATE CONTROL NUMBER (IF KNOWN) 000364564

PURSUANT TO THE PROVISIONS OF SECTION 48-20-106 OF *THE TENNESSEE BUSINESS CORPORATION ACT*, THE UNDERSIGNED CORPORATION ADOPTS THE FOLLOWING ARTICLES OF AMENDMENT TO ITS CHARTER:

1. PLEASE INSERT THE NAME OF THE CORPORATION AS IT APPEARS OF RECORD:
   Tenet HealthSystem Bartlett, Inc.

   IF CHANGING THE NAME, INSERT THE NEW NAME ON THE LINE BELOW:
   Saint Francis Hospital - Bartlett, Inc.

2. PLEASE MARK THE BLOCK THAT APPLIES:

   ☒ AMENDMENT IS TO BE EFFECTIVE WHEN FILED BY THE SECRETARY OF STATE.
   ☐ AMENDMENT IS TO BE EFFECTIVE, _____ (MONTH, DAY, YEAR)

   (NOT TO BE LATER THAN THE 90TH DAY AFTER THE DATE THIS DOCUMENT IS FILED.) IF NEITHER BLOCK IS CHECKED, THE AMENDMENT WILL BE EFFECTIVE AT THE TIME OF FILING

3. PLEASE INSERT ANY CHANGES THAT APPLY:

   A. PRINCIPAL ADDRESS: _____ STREET ADDRESS
   _____ CITY STATE/COUNTY ZIP CODE

   B. REGISTERED AGENT: _____

   C. REGISTERED ADDRESS: _____ STREET ADDRESS
   _____ CITY TN STATE ZIP CODE COUNTY

   D. OTHER CHANGES: _____

4. THE CORPORATION IS FOR PROFIT.

5. THE MANNER (IF NOT SET FORTH IN THE AMENDMENT) FOR IMPLEMENTATION OF ANY EXCHANGE, RECLASSIFICATION, OR CANCELLATION OF ISSUED SHARES IS AS FOLLOWS:

6. THE AMENDMENT WAS DULY ADOPTED ON April 28, 2014 (MONTH, DAY, YEAR) BY (Please mark the block that applies):

   ☐ THE INCORPORATORS WITHOUT SHAREHOLDER ACTION, AS SUCH WAS NOT REQUIRED.
   ☒ THE BOARD OF DIRECTORS WITHOUT SHAREHOLDER APPROVAL, AS SUCH WAS NOT REQUIRED.
   ☐ THE SHAREHOLDERS.

Secretary
SIGNER'S CAPACITY

Kristina A. Mack
SIGNATURE

4/28/14
DATE

Kristina A. Mack
NAME OF SIGNER (TYPED OR PRINTED)

SS-4421 (Rev. 10/01) Filing Fee: $20.00 RDA 1678

7337.2729, 05/02/2014, 10:24:09, Received by Tennessee Secretary of State Tre Hargett

38

B0077-5732 04/02/2015 11:54 AM Received by Tennessee Secretary of State Tre Hargett

Tennessee Corporation Annual Report Form

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2015 Reporting Year: 2014

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Return completed form within 30 days to:
Tennessee Secretary of State
Attn: Annual Reports
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
Phone: (615) 741-2286

SOS Control Number: 364564
For-profit Corporation - Domestic Date Formed: 01/25/1999 Formation Locale: TENNESSEE

Name and Mailing Address:
Saint Francis Hospital - Bartlett, Inc.
ATTN LAW DEPT
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(1) Add or Change Mailing Address:

Principal Office Address:
1445 ROSS AVE STE 1400
DALLAS, TX 75202-2703

(2) Change Principal Office Address:

Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
800 S GAY ST STE 2021
KNOXVILLE, TN 37929-9710 (KNOX COUNTY)

(3) Change RA and/or RO Address ($20 fee):

Note: The Registered Office address must be a Tennessee address.

(4) Name and business address (with zip code) of the principal officers. Attach additional sheet if necessary.

Title	Name	Business Address	City, State, Zip
PRES	TIMOTHY P. ADAMS	1445 ROSS AVE STE 1400	DALLAS TX 75202
SEC	KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202
TREAS	TYLER C. MURPHY	1445 ROSS AVE STE 1400	DALLAS TX 75202

(5) Board of Directors names and business address (with zip code). Attach additional sheet if necessary.

___ Same as above officers, ___ None, pursuant to T.C.A. §48-18-101(c), or listed below.

Name	Business Address	City, State, Zip
PAUL A. CASTANON	1445 ROSS AVE STE 1400	DALLAS TX 75202
JEFFREY M. PETERSON	1445 ROSS AVE STE 1400	DALLAS TX 75202
ANTHONY L. SHOEMAKER	1445 ROSS AVE STE 1400	DALLAS TX 75202

(6) Signature: Kristina A. Mack (7) Date: 3/13/15

(8) Type/Print Name: KRISTINA A. MACK (9) Title: SECRETARYt

Instructions: Legibly complete the form above. Enclose a check made payable to the Tennessee Secretary of State. Sign and date this form and return to the address provided above.

SS-4444

RDA 1678

B0210-2887 03/21/2016 3:10 PM Received by Tennessee Secretary of State Tre Hargett

Tennessee Corporation Annual Report Form

File online at: http://TNBear.TN.gov/AR

Due on/Before: 04/01/2016 Reporting Year: 2015

Annual Report Filing Fee Due:
$20 if no changes are made in block 3 to the registered agent/office, or
$40 if any changes are made in block 3 to the registered agent/office

Return completed form within 30 days to:
Tennessee Secretary of State
Attn: Annual Reports
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
Phone: (615) 741-2286

SOS Control Number: 364564
For-profit Corporation - Domestic Date Formed: 01/25/1999 Formation Locale: TENNESSEE

Name and Mailing Address:
Saint Francis Hospital - Bartlett, Inc.
ATTN LAW DEPT
STE 1400
1445 ROSS AVE
DALLAS, TX 75202-2703

(1) Add or Change Mailing Address:

Principal Office Address:
1445 ROSS AVE STE 1400
DALLAS, TX 75202-2703

(2) Change Principal Office Address:

Registered Agent (RA) and Registered Office (RO) Address:
C T CORPORATION SYSTEM
800 S GAY ST STE 2021
KNOXVILLE, TN 37929-9710 (KNOX COUNTY)

(3) Change RA and/or RO Address ($20 fee):

Note: The Registered Office address must be a Tennessee address.

(4) Name and business address (with zip code) of the principal officers. Attach additional sheet if necessary.

Title	Name	Business Address	City, State, Zip
PRESIDENT	CHRISTOPHER LOCKE	1445 ROSS AVE STE 1400	DALLAS TX 75202
SECRETARY	KRISTINA A. MACK	1445 ROSS AVE STE 1400	DALLAS TX 75202
TREASURER	TYLER C. MURPHY	1445 ROSS AVE STE 1400	DALLAS TX 75202

(5) Board of Directors names and business address (with zip code). Attach additional sheet if necessary.

___ Same as above officers, ___ None, pursuant to T.C.A. §48-18-101(c), or listed below.

Name	Business Address	City, State, Zip
PAUL A. CASTANON	1445 ROSS AVE STE 1400	DALLAS TX 75202
STEVEN A. SCHAEFER	1445 ROSS AVE STE 1400	DALLAS TX 75202
ANTHONY L. SHOEMAKER	1445 ROSS AVE STE 1400	DALLAS TX 75202

(6) Signature: Kristina A. Mack (7) Date: 3/17/16

(8) Type/Print Name: KRISTINA A. MACK (9) Title: SECRETARY

Instructions: Legibly complete the form above. **Enclose a check made payable to the Tennessee Secretary of State.** Sign and date this form and return to the address provided above.

SS-4444 RDA 1678

Attachment Section A-6A

Option to Lease

CAPITAL GROWTH
MEDVEST

361 SUMMIT BLVD, SUITE 220
BIRMINGHAM, ALABAMA 35243
WWW.MEDVEST.COM

LETTER OF INTENT

November 10, 2016
December 22, 2016 Revised for actual Land Costs

Re: Free Standing Emergency Department ("FED")
TENET St. Francis - Bartlett
Arlington, Tennessee (NE Memphis)

This LOI proposal summarizes the terms and conditions under which Capital Growth MedVest, LLC and its affiliates or assigns ("MedVest") is prepared to conditionally capitalize and execute the development with projected costs for a free standing emergency department comprising 15,240 gross square feet with projected costs in the amount of up to U.S. $10,253,223 or a total approved development budget to include: land purchase, hard, soft, equity, debt and finance costs during construction. We acknowledge that the project is contingent on a Certificate of Need, for which application has been made and expectations are that the project could commence prior to a land purchase expiration date goal of April 2017.

Landlord: A stand-alone LLC that is one or more special purpose entities to be formed by MedVest, LLC, its affiliates or assigns ("MedVest") and will be the fee simple owner and landlord of the real estate improvements.

Developer/Sponsor: Capital Growth MedVest, LLC

Tenants: 1) Single operator FED Tenant

Construction Period: 8 months

Capitalized Amount: The amount capitalized shall be in the amount of up to $10,253,223 or equal to 100% of approved construction budget to include ground lease, hard, soft and finance and interest costs during construction; less

any amounts contributed by TENET St Francis - Bartlett. For the CG MedVest funded portion, required equity is envisioned to be up to $1,537,984 (= 15%) plus total debt up to $8,715,240.

Investment Closing: Funding would take place within thirty business days after the successful conclusion of MedVest's 90-day due diligence period.

Land Purchase: MedVest will contract for the purchase of up to:

1.50 acres "corner" =	**$ 850,000**
2.00 acres of adjacent property =	**$ 740,520**
3.50 acres for a total land cost =	**$ 1,590,520**

Conditions: The terms outlined above are subject to approval of MedVest's Investment Committee, as well as its due diligence and acceptable reimbursement agreement, development agreement and tenant lease(s).

Due Diligence: Subject to an acceptable reimbursement agreement, up to $100,000 could be spent (and applied to the purchase price) to extend the land purchase Closing to at the soonest April 28, 2017. Over a 90-day period following the execution of a reimbursement agreement, MedVest will perform customary real estate due diligence including title, survey, appraisal, environmental, and financial and legal due diligence as well as threshold documents for a development agreement and tenant lease. In addition to the land deposits, due diligence expenses could be $100,000.

Development Budget:

$ 1,590,520	**Land Costs**
$ 1,200,000	**Site Improvements**
$ 250,000	**Additional utilities**
$ 1,881,850	**Building Shell (15,240 sf)**
$ 3,470,625	**Turnkey Build-out**
$ 114,000	**Ext Signage & Tele/Data**
$ 675,198	**Soft Costs &Consultants**
$ 1,071,030	**Finance Costs & Fees**
$10,253,223	**TOTAL DEVELOPMENT COSTS**
$ 0	**TENET / St. Francis – Bartlett Contribution**
$10,253,223	**TOTAL to be funded by CG Medvest**

Lease Structure: NNN with date certain rent commencement date. ALL expenses are the responsibility of each respective tenant.

Lease Term:	20 year with 3 five-year renewals
Lease Guarantor:	Entity level of each Tenant.
Rent Payment:	Rent will be paid monthly in advance on the first of each month from Tenant to Landlord.
Rental Rate/Cost:	**Base Rent: $60.48 per square foot** Base rent is calculated as 8.99% return on costs = $ 921,715 first year, annual rent.
Rent Escalation:	The lesser of CPI or Two and one-half of one percent percent (2.00%) annually for term of the lease.
Rent Deposit:	Not required for Hospital tenants.
Exclusive:	TENET St. Francis - Bartlett is our client. Capital Growth Medvest is the authorized agent and real estate developer for the project.
Development Expenses:	***Subject to an acceptable Reimbursement Agreement:*** **Pre-development expenses will exceed $200,000 of out-of-pocket costs that will be funded by Capital Growth Medvest.** For cancellation for convenience by the Tenant, Tenant shall be responsible for all third party transaction expenses related to completion of requirements necessary to close transaction including, but not limited to: appraisal, environment, legal and other approved third party expenses. Tenant shall have the option to present costs for reimbursement, which will then be financed with the entire project. When the projects proceeds, all expenses will become reimbursable.
Termination:	***Subject to an acceptable Reimbursement Agreement:*** TENET St. Francis - Bartlett shall be entitled to terminate this letter of intent at any time after six (6) months by delivering written notice of termination to CG MedVest; provided that upon any such termination TENET St. Francis - Bartlett agrees to reimburse CG MedVest for all Approved Expenses incurred by CG MedVest prior to the date upon which such notice of termination is delivered. TENET St. Francis – Bartlett agrees to remit such reimbursement within fifteen (15) days after receipt of a reasonably detailed statement (together with appropriate back-up documentation) itemizing all Approved Expenses for which reimbursement is sought.

Expiration Of LOI: Pending a Reimbursement Agreement, Development Agreement & Tenant Lease execution.

This letter of intent is not a binding commitment, but instead constitutes an expression of the basic terms upon which the parties would be willing to enter into definitive documentation for construction of the Project. Except for the obligations of the parties under the sections captioned "Exclusive", "Expenses" and "Termination" above, which the parties agree shall be fully binding upon them, the terms outlined herein shall not be binding upon either party unless and until both parties have executed mutually acceptable definitive documentation to include a development agreement and tenant leases within the Project.

If the terms outlined above meet your approval, please countersign this letter in the space provided below. Execution and delivery of this letter by facsimile, email or other electronic means shall be as fully valid and binding as physical delivery of a manually-executed original.

Sincerely,

David S. Fowler
Managing Partner
Capital Growth MedVest, LLC

ACCEPTANCE:

TENET St. Francis - Bartlett

_____

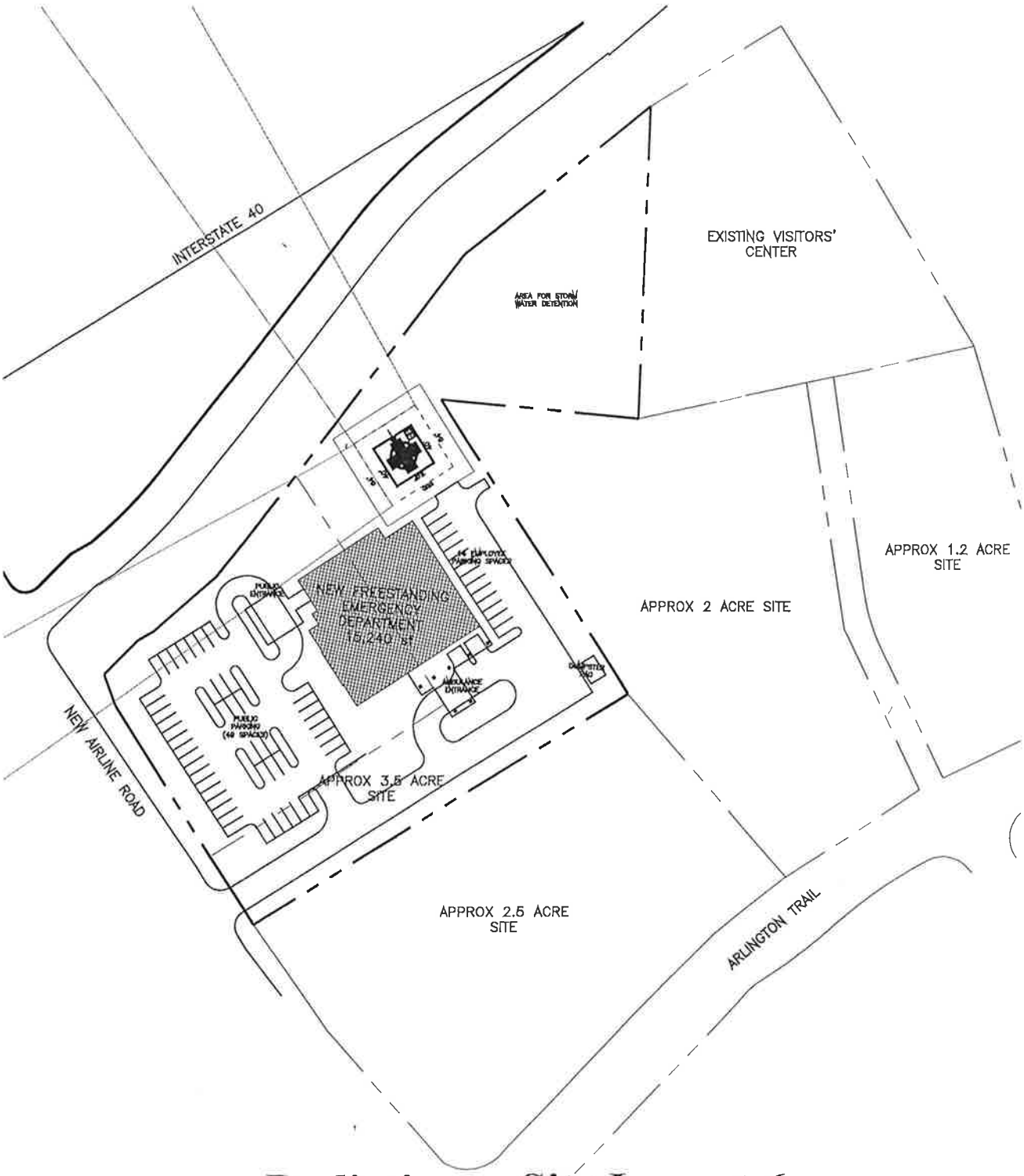
Name: _____

Title: _____

Date: _____

Attachment Section A-6B-1

Plot Plan



Preliminary Site Layout 6

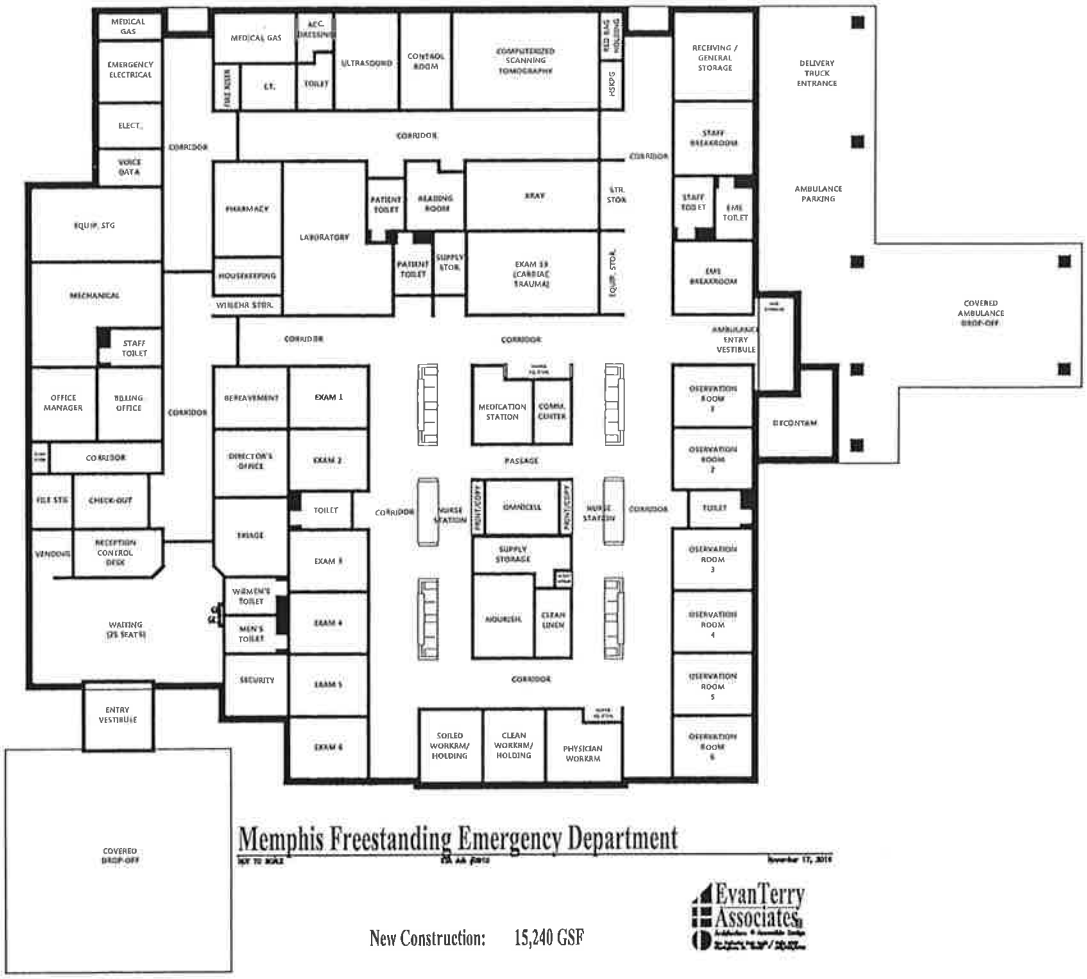
For

Memphis Freestanding Emergency Department

December 13, 2016
ETA # 3910

Attachment Section A 6-B2

Floor Plan



Memphis Freestanding Emergency Department

November 17, 2015

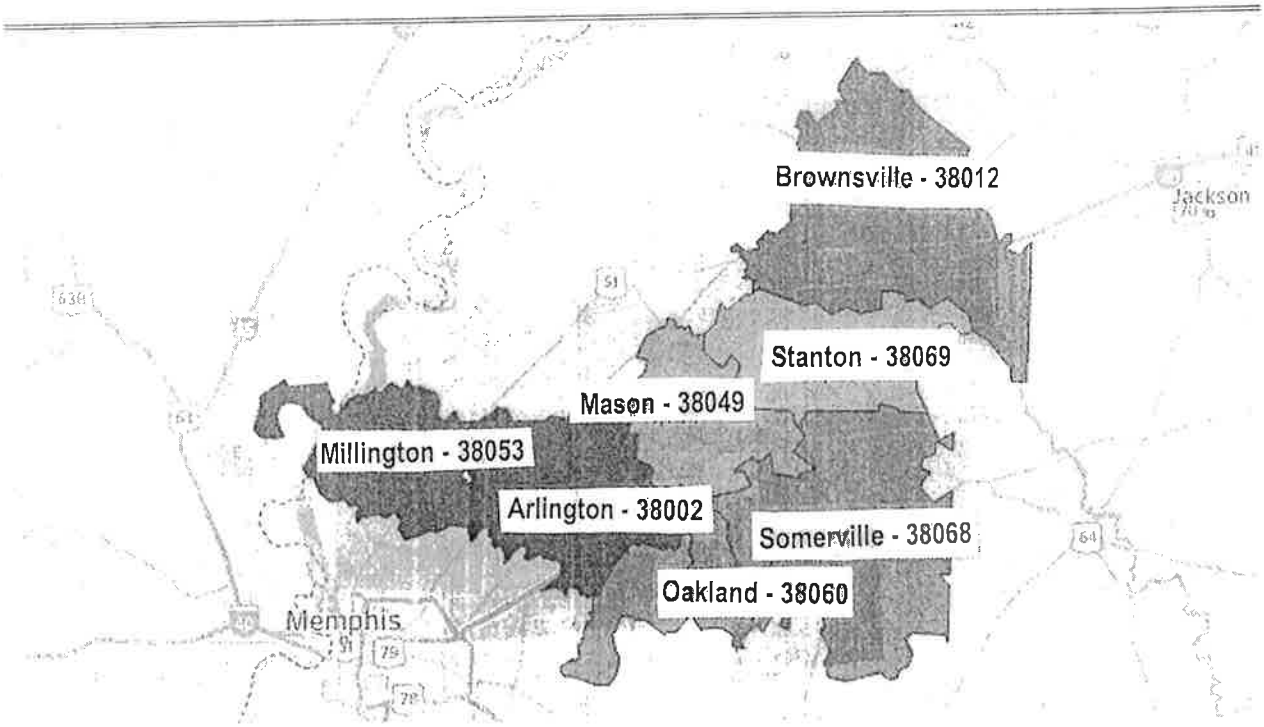
New Construction: 15,240 GSF

EvanTerry Associates

Attachment C, Need 3

Map of Service Area by Zip Code

SERVICE AREA ZIP CODE MAP



Attachment C - Economic Feasibility -1-e

Architect Letter

Evan Terry Associates

James L.E. Terry AIA
Neil H. King Jr. AIA

Jeffrey S. Fowler AIA
Todd R. Hollingsworth AIA
Dan E. Woosley AIA
Dennis N. Miles AIA
Pat Hodges AIA

January 5, 2017

RE: FREE-STANDING EMERGENCY DEPARTMENT
Tenet Saint Francis Hospital – Bartlett
Arlington, Tennessee
Construction Costs
ETA Project Number 3910

Evan Terry Associates, LLC, in working with Capital Growth MedVest, has developed the construction costs for site development and building construction. These costs are based on our experience in working on projects of similar type and scope, along with current market conditions. The estimated construction cost is broken down as follows:

Building Construction	15,240 SF @ $351.21/SF	$5,352,440.40
Site Development	3.5 Acres	$1,450,000.00
	TOTAL	$6,802,440.40

Based on our experience with this project type, these construction costs are reasonable to construct the project identified in the Certificate of Need application.

Sincerely,

EVAN TERRY ASSOCIATES, LLC

Neil H. King, Jr., AIA
President/COO

The project will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Evan Terry Associates / One Perimeter Park South / Suite 200S / Birmingham, AL 35243
Founded 1952 / Architecture / Universal-AccessibleDesign

PH 205 / 972 / 9100
FAX 205 / 972 / 9110
TTY 205 / 972 / 9112
www.evanterry.com

Attachment C - Economic Feasibility -2

Funding Documentation

Saint Francis Hospital - Bartlett

Tenet
Tennessee

2986 Kate Bond Road
Bartlett, TN 38133-4003
(901) 820-7000
http://www.saintfrancisbartlett.com

January 4, 2017

Melanie Hill, Executive Director
Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill,

RE: Application of Certificate of Need by Saint Francis Hospital – Bartlett for a Freestanding Emergency Department

This letter certifies that in consideration of Saint Francis Hospital – Bartlett filing the above – captioned for a Certificate of Need, Tenet Healthcare Corporation (Tenet), ultimate parent corporation of Saint Francis Hospital – Bartlett, makes the commitment to provide the necessary funding for the purpose of development of this project, which is not expected to exceed $2,300,941, if the project makes economic sense after the Certificate of Need has been approved.

Tenet Healthcare Corporation may fund this project utilizing either debt or cash flow from operations, or a combination thereof, as part of its overall capital investment budget. At this time, Tenet has sufficient resources to fully fund the expenditures described in this application along with its other ongoing obligations. In addition, Tenet Healthcare Corporation has a line of credit available to undertake projects such as this.
In addition to the commitment of the capital expenditure for this project, Tenet Healthcare Corporation hereby commits to provide working capital a necessary for this project,

Sincerely,

Doug Carter
Chief Financial Officer
Southern Region

JAN 13'17 PM3:51

Attachment C - Economic Feasibility - 6-A

SEC Filings

10-K 1 thc-20151231x10k.htm 10-K
Table of Contents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Form 10-K

☒ **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2015**

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
6⅞% 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 and posted on its corporate website every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes ☒ No ☐

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

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

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

Indicate by check mark whether the Registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

As of June 30, 2015, 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 $4.8 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 29, 2016, there were 98,529,352 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2016 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

Table of Contents

TABLE OF CONTENTS

		Page
PART I		
Item 1.	Business	1
Item 1A.	Risk Factors	30
Item 1B.	Unresolved Staff Comments	43
Item 2.	Properties	43
Item 3.	Legal Proceedings	43
Item 4.	Mine Safety Disclosures	43
PART II		
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	44
Item 6.	Selected Financial Data	46
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	48
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	106
Item 8.	Financial Statements and Supplementary Data	107
	Consolidated Financial Statements	110
	Notes to Consolidated Financial Statements	115
	Supplemental Financial Information	158
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	159
Item 9A.	Controls and Procedures	159
Item 9B.	Other Information	159
PART III		
Item 10.	Directors, Executive Officers and Corporate Governance	160
Item 11.	Executive Compensation	160
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	160
Item 13.	Certain Relationships and Related Transactions, and Director Independence	160
Item 14.	Principal Accounting Fees and Services	160
PART IV		
Item 15.	Exhibits and Financial Statement Schedules	161

Table of Contents

PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks, primarily in large urban and suburban markets in the United States. At the core of our networks are acute care and specialty hospitals that, together with our strategically aligned outpatient facilities and related businesses, allow us to provide a comprehensive range of healthcare services in the communities we serve. At December 31, 2015, we operated 86 hospitals, 20 short-stay surgical hospitals, over 475 outpatient centers, nine facilities in the United Kingdom and six health plans through our subsidiaries, partnerships and joint ventures. In addition, our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

With respect to our hospitals and outpatient businesses, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology, to recruit and retain physicians, and to negotiate competitive contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other, Ambulatory Care and Conifer. Additional information about our business segments is provided below, and financial and statistical data for the segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

In general, we seek to operate our hospitals, ambulatory care and other outpatient centers, and Conifer in a manner that positions them to compete effectively in an evolving healthcare environment. From time to time, we build new hospitals and outpatient centers, and make strategic acquisitions of hospitals, outpatient businesses, physician practices, and other healthcare assets and companies – in each case in markets where we believe our operating strategies can improve performance and create shareholder value. Moreover, we continually evaluate joint venture opportunities with other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum. In furtherance of the foregoing, during the year ended December 31, 2015:

- We combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into a new joint venture ("USPI joint venture"). We have a 50.1% ownership interest in the USPI joint venture, while Welsh, Carson, Anderson & Stowe, a private equity firm that specializes in healthcare investments, owns approximately 47% and Baylor University Medical Center ("Baylor") owns approximately 3% of the joint venture. We significantly increased the number of our not-for-profit partners through USPI and now have relationships with more than 50 leading healthcare systems across the country. Moreover, on December 31, 2015, USPI

acquired CareSpot Express Healthcare, which added 35 urgent care centers in Florida and Tennessee to its portfolio of outpatient centers.

- We formed a new joint venture with Baptist Health System, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership interest in the joint venture, and we manage the network's operations. Baptist Health System contributed four hospitals to the joint venture, and we contributed one hospital. The new network, which also includes each contributed hospital's related businesses, has more than 1,700 licensed beds, nine outpatient centers, 68 physician clinics delivering primary and specialty care, more than 7,000 employees, and approximately 1,500 affiliated physicians.

Table of Contents

- We entered into definitive agreements to form two joint ventures with Baylor Scott & White Health ("BSW") involving five North Texas hospitals. Effective January 1, 2016, one of the joint ventures owns or leases and operates Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center and Texas Regional Medical Center at Sunnyvale, all of which were previously owned or leased and operated by certain of our subsidiaries, and the other joint venture owns and operates Baylor Medical Center at Garland, which previously belonged to BSW. The two joint ventures will focus on delivering integrated, value-based care primarily to select communities in Rockwall, Collin and Dallas counties. BSW holds a 75% majority ownership interest in the joint venture that involves our legacy facilities and a 50.1% majority ownership interest in the joint venture that relates to the legacy BSW facility. We own the remaining minority interest in each joint venture and will continue to manage the operations of our legacy facilities. All five hospitals will operate under the BSW brand.

- We formed a new joint venture with Dignity Health and Ascension Arizona to own and operate Carondelet Health Network. We have a 60% ownership interest in the joint venture, and we manage the operations of the network's three hospitals with over 900 licensed beds, related physician practices, ambulatory surgery, imaging and urgent care centers, and other affiliated businesses in Tucson and Nogales, Arizona.

- We acquired European Surgical Partners Ltd. ("Aspen Healthcare" or "Aspen") in the United Kingdom. Although the U.K. provides government-funded healthcare to all of its residents through the National Health Service, the demand for healthcare services exceeds the public system's capacity. Aspen's four acute care hospitals, one cancer center and four outpatient facilities offer patients a complete range of private healthcare and clinical services in a growing market.

- We began operating Hi-Desert Medical Center and its related healthcare facilities under an arrangement structured as a long-term lease agreement with Hi-Desert Memorial Health Care District. We now manage the operations of the 59-bed acute care hospital, as well as a 120-bed skilled nursing facility, an ambulatory surgery center and an imaging center on the hospital's campus in Joshua Tree, California.

- We opened 16 new outpatient facilities, and we acquired 12 other outpatient businesses outside of the corporate development activities described above, as well as various physician practice entities.

- Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. At that time, CHI increased its minority ownership position in Conifer's revenue cycle solutions subsidiary, Conifer Health Solutions, LLC, to approximately 23.8%.

From time to time, we decide to sell, consolidate or close certain facilities to eliminate duplicate services or excess capacity or because of changing market conditions or other factors. During the year ended December 31, 2015, we completed the sale of Saint Louis University Hospital ("SLUH") to Saint Louis University, and we agreed to sell our two North Carolina hospitals – Central Carolina Hospital and Frye Regional Medical Center – and related operations to Duke LifePoint Healthcare (which sale was effective January 1, 2016). In addition, in December 2015, we entered into a definitive agreement for the sale and management of our Atlanta-area hospitals, as well as 26 physician clinics, to WellStar Health System. The transaction is subject to customary regulatory approvals and other closing conditions and is expected to be completed as early as the end of the first quarter of 2016. We also sold or closed nine outpatient centers in the year ended December 31, 2015.

We are committed to providing the communities we serve with high quality, cost-effective healthcare while growing our business, increasing our profitability and creating long-term value for our shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed in detail in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. In general, we anticipate the continued influence of major industry trends we have seen emerge over the last several years, and our strategies reflect the belief that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of a strengthening

Table of Contents

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

OPERATIONS

HOSPITAL OPERATIONS AND OTHER SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—At December 31, 2015, our subsidiaries operated 86 hospitals, including three academic medical centers, two children's hospitals, two specialty hospitals and two critical access hospitals, with a total of 22,525 licensed beds, serving primarily urban and suburban communities in 14 states. Our subsidiaries owned 67 of those hospitals, 12 were owned by entities that are, in turn, jointly owned by a Tenet subsidiary and a strategic partner or group of physicians, and seven were owned by third parties and leased by our subsidiaries. In addition, at December 31, 2015, our subsidiaries operated a long-term acute care hospital and a skilled nursing facility and owned or leased and operated a number of medical office buildings, all of which were located on, or nearby, our hospital campuses. At December 31, 2015, our Hospital Operations and other segment also included: 174 outpatient centers, the majority of which are provider-based diagnostic imaging centers, freestanding urgent care centers, satellite emergency departments and provider-based ambulatory surgery centers; approximately 700 physician practices; and six health plans.

Our hospitals classified in continuing operations for financial reporting purposes generated in excess of 83% of our net operating revenues before provision for doubtful accounts for all periods presented in our Consolidated Financial Statements. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: (1)

the business environment, economic conditions and demographics of local communities in which we operate; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local healthcare competitors; (8) managed care contract negotiations or terminations; (9) the number of patients with high-deductible health insurance plans; (10) any unfavorable publicity about us, which impacts our relationships with physicians and patients; (11) changes in healthcare regulations and the participation of individual states in federal programs; and (12) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most have intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals provide tertiary care services, such as open-heart surgery, neonatal intensive care and neurosciences, and some also offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Our children's hospitals provide tertiary and quaternary pediatric services, including bone marrow and kidney transplants, as well as burn services. Moreover, a number of our hospitals offer advanced treatment options for patients, including gamma-knife brain surgery and cyberknife radiation therapy for tumors and lesions in the brain, lung, neck, spine and elsewhere that may previously have been considered inoperable or inaccessible by traditional radiation therapy. Many of our hospitals and physician practices also offer a wide range of clinical research studies, giving patients access to innovative care. We are dedicated to helping our hospitals and physicians participate in medical research that is consistent with state and federal regulations and complies with clinical practice guidelines. Clinical research programs relate to a wide array of ailments, including cardiovascular disease, pulmonary disease, musculoskeletal disorders, neurological disorders, genitourinary disease and various cancers, as well as experimental drug and medical device studies. By supporting clinical research, our hospitals are actively involved in medical advancements that can lead to improvements in patient safety and clinical care.

Table of Contents

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

The following table lists, by state, the hospitals wholly owned, owned as part of a joint venture or leased and operated by our subsidiaries at December 31, 2015:

Hospital	Location	Licensed Beds	Status
Alabama			
Baptist Medical Center – Princeton[1]	Birmingham	505	JV
Brookwood Medical Center[1]	Birmingham	607	JV
Citizens Baptist Medical Center[1]	Talladega	122	JV
Shelby Baptist Medical Center[1]	Alabaster	252	JV
Walker Baptist Medical Center[1]	Jasper	267	JV
Arizona			
Abrazo Arizona Heart Hospital[2]	Phoenix	59	Owned
Abrazo Arrowhead Campus	Glendale	217	Owned
Abrazo Central Campus	Phoenix	221	Owned
Abrazo Maryvale Campus	Phoenix	232	Owned
Abrazo Scottsdale Campus	Phoenix	136	Owned
Abrazo West Campus	Goodyear	188	Owned

Holy Cross Hospital[3], [4]	Nogales	25	JV
St. Joseph's Hospital[3]	Tucson	486	JV
St. Mary's Hospital[3]	Tucson	400	JV
California			
Desert Regional Medical Center[5]	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center of Modesto	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center[6]	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center[7]	San Ramon	123	JV
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Florida Medical Center - a campus of North Shore	Lauderdale Lakes	459	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
Palm Beach Gardens Medical Center[8]	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
St. Mary's Medical Center	West Palm Beach	464	Owned
West Boca Medical Center	Boca Raton	195	Owned

Table of Contents

Hospital	Location	Licensed Beds	Status
Georgia			
Atlanta Medical Center[9]	Atlanta	762	Owned
Atlanta Medical Center – South Campus[9], [10]	East Point	—	Owned
North Fulton Hospital[9], [11]	Roswell	202	Leased
Spalding Regional Hospital[9]	Griffin	160	Owned
Sylvan Grove Hospital[9], [12]	Jackson	25	Leased
Illinois			
Louis A. Weiss Memorial Hospital	Chicago	236	Owned
MacNeal Hospital	Berwyn	368	Owned
West Suburban Medical Center	Oak Park	234	Owned
Westlake Hospital	Melrose Park	230	Owned
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	147	Owned
MetroWest Medical Center – Leonard Morse Campus	Natick	152	Owned
Saint Vincent Hospital	Worcester	283	Owned

Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	273	Owned
Harper University Hospital	Detroit	584	Owned
Huron Valley-Sinai Hospital	Commerce Township	158	Owned
Hutzel Women's Hospital[13]	Detroit	—	Owned
Rehabilitation Institute of Michigan[2]	Detroit	97	Owned
Sinai-Grace Hospital	Detroit	404	Owned
Missouri			
Des Peres Hospital	St. Louis	143	Owned
North Carolina			
Central Carolina Hospital[14]	Sanford	137	Owned
Frye Regional Medical Center[14], [15]	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher's Hospital for Children	Philadelphia	189	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned

Table of Contents

Hospital	Location	Licensed Beds	Status
Texas			
Baptist Medical Center	San Antonio	623	Owned
Centennial Medical Center[16]	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake[17]	Dallas	218	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	323	Owned
Houston Northwest Medical Center[18]	Houston	423	JV
Lake Pointe Medical Center[19]	Rowlett	112	JV
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
North Central Baptist Hospital	San Antonio	387	Owned
Northeast Baptist Hospital	San Antonio	371	Owned
Park Plaza Hospital	Houston	444	Owned
Resolute Health Hospital	New Braunfels	128	Owned
St. Luke's Baptist Hospital	San Antonio	282	Owned
Texas Regional Medical Center at Sunnyvale[20]	Sunnyvale	70	JV/Leased
Valley Baptist Medical Center[21]	Harlingen	586	Owned

Valley Baptist Medical Center – Brownsville[21]	Brownsville	280	Owned
Total Licensed Beds		22,525	

(1) Owned by a limited liability company formed as part of a joint venture with Baptist Health System, Inc., a not-for-profit, faith-based integrated system of doctors, hospitals and other healthcare services in Alabama; a Tenet subsidiary owned a 60% interest in the limited liability company at December 31, 2015, and Baptist Health System, Inc. owned a 40% interest.
(2) Specialty hospital.
(3) Owned by a limited liability company formed as part of a joint venture with Dignity Health and Ascension Arizona, each of which is a not-for-profit, faith-based health system; a Tenet subsidiary owned a 60% interest in the limited liability company at December 31, 2015, Dignity Health owned a 22.5% interest and Ascension Arizona owned a 17.5% interest.
(4) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital.
(5) Lease expires in May 2027.
(6) Lease expires in July 2045.
(7) Owned by a limited liability company formed as part of a joint venture with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other healthcare services in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2015, and John Muir Health owned a 49% interest.
(8) Lease expires in February 2017, but may be renewed through at least February 2037, subject to certain conditions contained in the lease.
(9) Subject of a definitive sales agreement with WellStar Health System.
(10) Licensed beds for Atlanta Medical Center – South Campus are presented on a combined basis with Atlanta Medical Center.
(11) Lease expires in February 2020, but may be renewed through at least February 2040, subject to certain conditions contained in the lease.
(12) Designated by CMS as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation. The current lease term for this facility expires in December 2016, but may be renewed through December 2046, subject to certain conditions contained in the lease.
(13) Licensed beds for Hutzel Women's Hospital are presented on a combined basis with Harper University Hospital.
(14) Sold effective January 1, 2016 to Duke LifePoint Healthcare.
(15) Lease expires in February 2022, but may be renewed through at least February 2042, subject to certain conditions contained in the lease.
(16) As of January 1, 2016, managed by a Tenet subsidiary and owned by a limited partnership that is owned by a limited liability partnership (the "JV LLP") formed as part of a joint venture with Baylor Scott & White Health, a not-for-profit healthcare system; a Tenet subsidiary owns a 25% interest in the JV LLP, and BSW owns a 75% interest.
(17) As of January 1, 2016, managed by a Tenet subsidiary and owned by the JV LLP.
(18) Owned by a limited liability company in which a Tenet subsidiary owned an 87.48% interest at December 31, 2015 and is the managing member.
(19) At December 31, 2015, owned by a limited liability company in which a Tenet subsidiary owned a 94.67% interest and was the managing member. As of January 1, 2016, managed by a Tenet subsidiary and owned by a limited liability company in which the JV LLP indirectly owns the 94.67% interest.
(20) At December 31, 2015, leased by a limited liability company in which a Tenet subsidiary owned a 55% interest and was the managing member. As of January 1, 2016, managed by a Tenet subsidiary and leased by a limited liability company in which the JV LLP indirectly owns the 55% interest. The current lease term for this hospital expires in November 2029, but may be renewed through at least November 2049, subject to certain conditions contained in the lease.
(21) At December 31, 2014, Valley Baptist Medical Center and Valley Baptist Medical Center – Brownsville were indirectly owned by a limited liability company formed as part of a joint venture with VB Medical Holdings, a Texas non-profit corporation ("VBMH"); a Tenet subsidiary owned a 51% interest in the limited liability company and was the managing member, and VBMH owned a 49% interest. We subsequently acquired VBMH's 49% interest in the limited liability company pursuant to the terms of the operating agreement governing the joint venture. As a result, we own 100% of both hospitals as of February 11, 2015.

Table of Contents

Information regarding the total number of hospitals operated by our subsidiaries, the collective number of licensed beds at those facilities, the utilization of licensed beds and other operating statistics at December 31, 2015, 2014 and 2013 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, 2015, our Hospital Operations and other segment also included 69 diagnostic imaging centers, 14 satellite emergency departments, 13 ambulatory surgery centers and seven urgent care centers operated as departments of our hospitals and under the same license, as well as 71 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of eight diagnostic imaging centers, five emergency departments, three ambulatory surgery centers and 55 urgent care centers, the majority of which are operated under our national MedPost brand. Our subsidiaries wholly own and operate most of the freestanding outpatient centers in our Hospital Operations and other segment. Over 50% of the outpatient centers in our Hospital Operations and other segment at December 31, 2015 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 help us contract more successfully with

managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Health Plans and Accountable Care Networks—During the year ended December 31, 2015, we operated six health plans with approximately 139,000 members:

- VHS Phoenix Health Plan, Inc. (formerly known as VHS Phoenix Health Plan, LLC), a Medicaid-managed health plan operating as Phoenix Health Plan ("PHP") in Arizona;
- Phoenix Health Plans, Inc. (formerly known as Abrazo Advantage Health Plan, Inc.), a Medicare, Medicaid dual-eligible and public health insurance exchange managed health plan operating in Arizona;
- Golden State Medicare Health Plan, a health maintenance organization ("HMO") that specializes in the care of seniors in Southern California who are eligible for benefits under the Medicare Advantage program;
- Chicago Health System, Inc. ("CHS"), a contracting entity formed to establish a preferred provider network for inpatient and outpatient services provided by MacNeal Hospital, Louis A. Weiss Memorial Hospital and participating physicians in the Chicago area;
- Harbor Health Plan, Inc. (formerly known as ProCare Health Plan, Inc.), a Medicaid-managed, Medicare Advantage and public health insurance exchange health plan operating in Michigan; and
- Allegian Insurance Company (formerly known as Valley Baptist Insurance Company), doing business as Allegian Health Plan, which offers HMO, preferred provider organization ("PPO"), and self-funded products to its members in the form of large group, small group and individual product offerings in south Texas, as well as a Medicare Advantage and public health insurance exchange health plan.

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

We also own, control or operate 14 accountable care networks – in Alabama, California, Florida, Georgia, Illinois, Michigan, Missouri, Pennsylvania and Texas – and participate in three additional accountable care networks with other healthcare providers in our markets in Arizona, California and Massachusetts. These networks operate using a

Table of Contents

range of payment and delivery models that seek to align provider reimbursement in a way that encourages improved quality metrics and efficiencies in the total cost of care for an assigned population of patients through cooperation of the providers. We believe that our experience operating health plans and accountable care networks gives us a solid framework upon which to build and expand our population health strategies.

AMBULATORY CARE SEGMENT

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. into our new USPI joint venture. We have a 50.1% ownership interest in the USPI joint venture, while Welsh, Carson, Anderson & Stowe, a private equity firm that specializes in healthcare investments, owns approximately 47% and Baylor University Medical Center owns approximately 3% of the joint venture. In addition, we completed the acquisition of Aspen Healthcare in the United Kingdom on June 16, 2015. In the three months ended June 30, 2015, we began reporting Ambulatory Care as a separate reportable business segment. Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our Aspen facilities. Our interests in the 49 ambulatory surgery centers and 20 imaging centers we contributed to the USPI joint venture had previously been included in our Hospital Operations and other segment.

USPI's Business—Our USPI joint venture acquires and develops its facilities primarily through the formation of strategic relationships with physicians and health system partners. Subsidiaries of the USPI joint venture hold ownership interests in the facilities directly or indirectly and operate the facilities on a day-to-day basis through management services contracts. We believe that this acquisition and development strategy and operating model will enable our USPI joint venture to continue to grow because of several previously noted industry trends we have seen emerge over the last several years, namely that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of a strengthening economy, shifting demographics and the expansion of coverage under the Affordable Care Act; and (5) payer reimbursements will be constrained and further shift to being more closely tied to performance on quality and service metrics.

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

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

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

Table of Contents

costs, more efficient staffing and space utilization, and a specialized operating environment focused on quality of care and cost containment.

We believe that our USPI joint venture's facilities (1) enhance the quality of care and the healthcare experience of patients, (2) offer a strategic approach for physicians that provides them with significant administrative, clinical and economic benefits, (3) offer a strategic approach for our health system partners to diversify and expand capacity and access within the markets they serve, and (4) offer an efficient and low-cost alternative for payers and employers. We operate our facilities, structure our strategic relationships, 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 strategic relationships enable healthcare systems to offer patients, physicians and payers the cost advantages, convenience and other benefits of ambulatory care in a freestanding facility and, in certain markets, establish networks needed to manage the full continuum of care for a defined population. Further, these relationships allow the healthcare systems to focus their attention and resources on their core business without the challenge of acquiring, developing and operating these facilities.

At December 31, 2015, our USPI joint venture operated 249 ambulatory surgery centers, 20 short-stay surgical hospitals, 20 imaging centers and 35 urgent care centers (acquired from CareSpot Express Healthcare on that date) in 28 states. Of these 324 facilities, 181 are jointly owned with health system partners. Due in large part to these relationships, we do not consolidate the financial results of 139 of the facilities in which our USPI joint venture has an ownership interest, meaning that while we record a share of their net profit within our operating income as equity earnings of unconsolidated affiliates, we do not include their revenues and expenses in the consolidated revenue and expense line items of our consolidated financial statements. For additional information, see Note 1 to our Consolidated Financial Statements.

Aspen's Business—The United Kingdom provides government-funded healthcare to all of its residents through the National Health Service; however, due to funding and capacity limitations, the demand for healthcare services exceeds the public system's capacity. In response to these shortfalls, private healthcare networks and private insurance companies have developed in the U.K. Aspen Healthcare's nine facilities offer patients a complete range of private healthcare and clinical services as described below:

- Cancer Centre London in South West London provides advanced outpatient cancer treatment, including radiotherapy and chemotherapy, as well as a number of related support services; inpatient cancer treatment is provided at our nearby Parkside Hospital.

- The Chelmsford, a private day surgery hospital located northeast of London in Essex, specializes in outpatient and minimally invasive treatment and surgery.

- Claremont Private Hospital, a 41-bed acute care facility in Sheffield, offers an extensive range of inpatient and outpatient services.

- The Edinburgh Clinic, a private surgical hospital in Scotland, offers outpatient procedures and on-site diagnostic imaging.

- Highgate Private Hospital, located in North London, is a 43-bed facility providing a wide range of inpatient and outpatient services.

- The Holly Private Hospital, a 55-bed facility located in Essex, is an acute care inpatient hospital that also offers numerous outpatient services.

- Midland Eye, a private ambulatory surgery center located in West Midlands, provides specialist eye care and surgery in a dedicated facility.

Table of Contents

- Nova Healthcare, a private clinic housed within Leeds Cancer Centre, offers treatment to private patients diagnosed with cancer, blood disorders and a range of neurological diseases.

- Parkside Hospital, located in Wimbledon, a suburb southwest of London, has 69 registered acute care beds and an outpatient surgery unit.

As with our USPI joint venture, a number of Aspen's facilities are owned jointly with physicians and health system partners.

CONIFER SEGMENT

Our Conifer subsidiary provides a number of services primarily to healthcare providers to assist them in generating sustainable improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. At December 31, 2015, Conifer provided one or more of the business process services described below from 20 service centers to more than 800 Tenet and non-Tenet hospital and other clients in over 40 states.

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

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

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

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

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

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

- ongoing measurement and monitoring of key revenue cycle metrics.

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

Patient Communications and Engagement Services—Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referrals, calls regarding maternity services and other patient inquiries, (2) community education and outreach, (3) scheduling and appointment reminders, and (4) employee recruitment. Conifer also coordinates and implements mail-based marketing programs to keep patients informed of screenings, seminars and other events and services, as well as conducts patient quality and satisfaction surveys to provide valuable feedback to its clients. In addition, Conifer provides clinical admission reviews that are intended to provide evidence-based support for physician decisions on patient status and reduce staffing costs.

Management Services—Conifer also supports value-based performance through clinical integration, financial risk management and population health management, all of which assist hospitals,

physicians, accountable care organizations ("ACOs"), health plans, self-insured employers and government agencies in improving the cost and quality of healthcare delivery, as well as patient outcomes. Conifer helps clients build clinically integrated networks that provide predictive analytics and quality measures across the care continuum. In addition, Conifer assists clients in improving both the cost and quality of care by aligning and managing financial incentives among healthcare

Table of Contents

stakeholders through risk modeling and management for various payment models. Furthermore, Conifer offers clients tools and analytics to improve quality of care and provide care management support for patients with chronic diseases by identifying high-risk patients and monitoring clinical outcomes.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. We believe that our success in growing Conifer and increasing its profitability depends in part on our success in executing the following strategies: (1) attracting as new clients hospitals and other healthcare providers who currently handle their revenue cycle management processes internally; (2) generating new client relationships through opportunities from USPI and Tenet's acute care hospital corporate development activities; (3) expanding revenue cycle management and value-based care service offerings through organic development and small acquisitions; (4) leveraging data from tens of millions of patient interactions to capture new opportunities and service the value-based care environment to drive competitive differentiation; and (5) developing services for our Ambulatory Care segment, leveraging USPI's capabilities.

In May 2012, Conifer entered into a 10-year agreement with Catholic Health Initiatives to provide revenue cycle services for 56 of CHI's hospitals. As part of this initial relationship, CHI received a minority ownership interest in Conifer's revenue cycle solutions subsidiary, Conifer Health Solutions, LLC. In January 2015, Conifer announced a 10-year extension and expansion of its agreement with CHI to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. As further described in Note 16 to our Consolidated Financial Statements, at that time, CHI increased its minority ownership position in Conifer Health Solutions, LLC to approximately 23.8%.

The loss of Conifer's key customers, primarily Tenet and CHI, in the future could have a material adverse impact on the segment; however, CHI is not a key customer to Tenet on a consolidated basis. Financial and other information about our Conifer operating segment is provided in the Consolidated Financial Statements included in this report.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2015 are set forth in the table beginning on page 4. 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 period, in some cases for up to 10 additional years. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own nearly all of our medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

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

INTELLECTUAL PROPERTY

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

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

Table of Contents

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

PHYSICIANS AND EMPLOYEES

Physicians—Our operations depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and who affiliate with us and use our facilities as an extension of their practices. Under state laws and other licensing standards, medical staffs are generally self-governing organizations subject to ultimate oversight by the facility's local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing facilities at any time. At December 31, 2015, we owned approximately 700 physician practices, and we employed (where permitted by state law) or otherwise affiliated with over 2,000 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals and outpatient centers. It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance.

Employees—At December 31, 2015, we employed over 130,000 people (of which 23% were part-time employees) in the following categories:

Hospital Operations and other[1]	102,850
Administrative offices	2,100
Ambulatory Care[2]	14,820
Conifer	14,860
Total	134,630

(1) Includes employees at (a) our general hospitals, specialty hospitals, critical access hospitals, long-term acute care hospital and skilled nursing facility, (b) the ambulatory surgery centers, imaging centers, urgent care centers and satellite emergency departments in our Hospital Operations and other segment, (c) our physician practices, (d) our health plans and accountable care networks, and (e) and other related healthcare operations.

(2) Includes employees at (a) the short-stay surgical facilities, imaging centers and urgent care centers in our Ambulatory Care segment, and (b) Aspen's four acute care hospitals, one cancer center and four outpatient facilities, as well as corporate and administrative employees supporting those facilities.

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

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

Union Activity and Labor Relations—At December 31, 2015, approximately 20% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 37 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating first contracts at two of our hospitals where employees selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries,

Table of Contents

wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation.

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

COMPETITION

HEALTHCARE SERVICES

Our hospitals, outpatient centers and other healthcare businesses operate in competitive environments, primarily at the local level. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, competing facilities (1) may offer a broader array of services to patients and physicians than ours, (2) may have larger or more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, (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 in specific geographic markets.

We also face competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high-margin services and for quality physicians and personnel. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations. These tax-exempt competitors may have certain

financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. In addition, in certain markets in which we operate, large teaching hospitals provide highly specialized facilities, equipment and services that may not be available at our hospitals.

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

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

Our strategies are designed to help our hospitals and outpatient facilities remain competitive. We believe targeted capital spending on critical growth opportunities, emphasis on higher-demand clinical service lines (including outpatient lines), implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. Furthermore, we have significantly expanded our outpatient business, and we have increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, increased predictability and efficiency for physicians, and lower costs for payers. We have also sought to include all of our hospitals and other healthcare businesses in the related geographic area or nationally when negotiating

Table of Contents

new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks.

We are continuing to make significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. In addition, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effects of: (1) reducing costs; (2) increasing payments from Medicare and certain managed care payers for our services as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others; and (3) increasing physician and patient satisfaction, which may improve our volumes.

In addition, in several markets, we have formed clinically integrated organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

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

REVENUE CYCLE MANAGEMENT SOLUTIONS

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

- software vendors and other technology-supported revenue cycle management business process outsourcing companies;
- traditional consultants, either specialized healthcare consulting firms or healthcare divisions of large accounting firms; and
- large, non-healthcare focused business process and information technology outsourcing firms.

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

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

Table of Contents

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

HEALTHCARE REGULATION AND LICENSING

AFFORDABLE CARE ACT

The Affordable Care Act has changed how healthcare services in the United States are covered, delivered and financed. The primary goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. To fund the expansion of insurance coverage, the legislation

contains measures designed to promote quality and cost efficiency in healthcare delivery and to generate budgetary savings in the Medicare and Medicaid programs. In addition, the ACA contains provisions intended to strengthen fraud and abuse enforcement.

Health Insurance Market Reforms—One key provision of the ACA is the "individual mandate," which requires most Americans to maintain "minimum essential" health insurance coverage. Those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty. The penalty percentage increases through 2016 and is adjusted for inflation beginning in 2017. For individuals who are not exempt from the individual mandate, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Health insurance exchanges are government-regulated organizations that provide competitive markets for buying health insurance by offering individuals and small employers a choice of different health plans, certifying plans that participate, and providing information to help consumers better understand their options. Some states have elected to operate their own exchanges; in most states, however, individuals must utilize the federal government's health insurance exchange found online at HealthCare.gov. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Following legal challenges seeking to limit the availability of premium credits and subsidies only to individuals enrolled in coverage through a state-based exchange, the U.S. Supreme Court in June 2015 upheld U.S. Internal Revenue Service ("IRS") regulations extending such subsidies to individuals who purchase coverage through the federal government's health insurance exchange.

The "employer mandate" provision of the ACA requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. In February 2014, the requirements of the employer mandate were partially delayed. Employers with 100 or more full time equivalent employees were required to insure at least 70% of their employees beginning in 2015 and 95% of their employees by 2016; employers with 50-99 full time equivalent employees are required to start insuring their employees in 2016. We cannot predict what action the federal government might take to lift or extend the delay or the impact of any such action on insurance coverage.

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

- may not establish lifetime or annual limits on the dollar value of benefits;
- may not rescind coverage of an enrollee, except in instances where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact;
- must reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place; and
- must continue to make dependent coverage available to unmarried dependents until age 26 (coverage for the dependents of unmarried adult children is not required) effective for health plan policy years beginning on or after September 23, 2010 (for plans that offer dependent coverage).

Public Program Reforms—Another key provision of the Affordable Care Act is the expansion of Medicaid coverage. Prior to the passage of the ACA, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The ACA expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. Under the ACA, the federal government will pay 100% of the costs of Medicaid expansion in 2015 and 2016; federal funding will be reduced to 90% over the course of the four-year period from 2017 through 2020, and it will remain at 90% for 2021 and beyond. The expansion of the Medicaid program in each state is not mandatory — it requires state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. There is no deadline for a state to undertake expansion and qualify for the enhanced federal funding available under the Affordable Care Act. At December 31, 2015, 31 states and the District of Columbia had taken action to expand Medicaid, and one other was considering action to expand in the near future. We currently operate hospitals in six of the states (Arizona, California, Illinois, Massachusetts, Michigan and Pennsylvania) that have expanded their Medicaid programs. We cannot provide any assurances as to whether or when the other states in which we operate might choose to expand their Medicaid programs or whether those states that do expand their Medicaid programs will continue to offer expanded eligibility in the future.

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

- negative adjustments to the annual input price index, or "market basket," updates for Medicare's inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and

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

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

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

Program Integrity and Fraud and Abuse—The Affordable Care Act also contains a number of provisions relating to the Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments, Section 1877 of the Social Security Act (commonly referred to as the "Stark" law), and qui tam or "whistleblower" actions, some of which are described in detail below. The ACA provides additional enforcement tools to the government, facilitates cooperation

between agencies by establishing mechanisms for the sharing of information, and enhances criminal and administrative penalties for non-compliance. For example, the ACA: (1) provides $350 million in increased federal funding over 10 years to fight healthcare fraud, waste and abuse; (2) authorizes the U.S. Department of Health and Human Services ("HHS"), in consultation with the Office of Inspector General ("OIG"), to suspend Medicare and Medicaid payments to a provider of services or a supplier "pending an investigation of a credible allegation of fraud;" (3) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (4) strengthens the rules for returning overpayments made by governmental health programs and expands liability under the federal False Claims Act ("FCA") to include failure to timely repay identified overpayments.

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

- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);
- how many currently uninsured individuals will ultimately obtain and retain insurance coverage (either private health insurance or Medicaid) as a result of the ACA;
- what percentage of our newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- future changes in the rates paid to hospitals by private payers for newly covered individuals, including those covered through health insurance exchanges and those who might be covered under the Medicaid program under contracts with a state;
- future changes in the rates paid by state governments under the Medicaid program for newly covered individuals;
- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the enhanced program integrity and fraud and abuse provisions lead to a greater number of civil or criminal actions or impact Medicare and Medicaid payments to us; and
- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

We also cannot predict the outcome of continuing legal challenges to certain provisions of the ACA or what action, if any, Congress might take with respect to the ACA. Any action that negatively impacts the number of individuals who have health insurance coverage could have a material adverse effect on our results of operations and cash flows.

Table of Contents

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

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are fully implemented;
- whether future reductions required by the ACA will be changed by statute prior to becoming effective;
- the size of the annual productivity adjustment to the market basket;
- the reductions to Medicaid DSH payments commencing in FFY 2018;
- what the losses in revenues, if any, will be from the ACA's quality initiatives;
- how successful accountable care networks and other pilot programs in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement; and
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs.

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

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, under the Affordable Care Act, submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act. 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.

Table of Contents

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

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

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

Implications of Fraud and Abuse Laws—At December 31, 2015, three of our hospitals in our Hospital Operations and other segment, and the majority of the facilities that operate as hospitals in our Ambulatory Care segment, are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals. Furthermore, the majority of ambulatory surgery centers in our Ambulatory Care segment, which are owned by joint ventures that include some physician and health system partners, 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

Table of Contents

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 laws and regulations, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. For example, we cannot predict whether physicians may ultimately be restricted from holding ownership interests in hospitals or whether the exception relating to services provided by ambulatory surgery centers could be eliminated. We are continuing to enter into new financial arrangements with physicians and other providers in a manner we believe complies in all material respects with applicable anti-kickback and anti-fraud and abuse laws. However, governmental officials responsible for enforcing these laws may nevertheless assert that we are in violation of these provisions. In addition, these statutes or regulations may be interpreted and enforced by the courts in a manner that is not consistent with our interpretation.

In accordance with our ethics and compliance program, which is described in detail under "Compliance and Ethics" below, we have policies and procedures in place concerning compliance with the Anti-kickback Statute and the Stark law, among others. In addition, our ethics and compliance, law and audit services departments systematically review a substantial number of our arrangements with referral sources to determine the extent to which they comply with our policies and procedures and with the Anti-kickback Statute, the Stark law and similar state statutes. On the one hand, we may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors and exceptions to the fraud and abuse laws described above; as a result, this unwillingness may put us at a competitive disadvantage. On the other hand, we cannot assure you

that the regulatory authorities that enforce these laws will not determine that some of our arrangements violate the Anti-Kickback Statute, the Stark law or other applicable regulations. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that our USPI joint venture or its subsidiaries has violated any of these laws could give certain of our health system partners a right to terminate their relationships with us; and any similar determination with respect to Conifer or any of its subsidiaries could give Conifer's customers the right to terminate their services agreements with us. Moreover, any violations by and resulting penalties or exclusions imposed upon USPI's health system partners or Conifer's customers could adversely affect their financial condition and, in turn, have a material adverse effect on our business and results of operations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

To receive reimbursement from CMS for electronic claims, healthcare providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain healthcare information electronically. Effective October 1, 2015, CMS changed the formats used for certain electronic transactions and began requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. Although use of the ICD-10 code sets required significant modifications to our payment systems and processes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse

Table of Contents

effect on our business, financial condition, results of operations or revenues. Furthermore, the Affordable Care Act required HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction. Our electronic data transmissions are compliant with current standards.

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

In 2009, HIPAA was amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act to impose certain of the HIPAA privacy and security requirements directly upon business associates of covered entities and significantly increase the monetary penalties for violations of HIPAA. Regulations that took effect in late 2009 also require business associates such as Conifer to notify covered entities, who in turn must notify affected individuals and government

authorities, of data security breaches involving unsecured PHI. Since the passage of the HITECH Act, enforcement of HIPAA violations has increased. A knowing breach of the HIPAA privacy and security requirements made applicable to business associates by the HITECH Act could expose Conifer to criminal liability, and a breach of safeguards and processes that is not due to reasonable cause or involves willful neglect could expose Conifer to significant civil penalties and the possibility of civil litigation under HIPAA and applicable state law.

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

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

HEALTH PLAN REGULATORY MATTERS

Our health plans are subject to numerous federal and state laws and regulations related to their business operations, including, but not limited to: the form and content of member contracts, including certain mandated benefits; premium rates and medical loss ratios; the content of agreements with participating providers; claims processing and appeals; underwriting practices; reinsurance arrangements; protecting the privacy and confidentiality of the information received from members; risk-sharing arrangements with providers; the quality of care provided to beneficiaries; reimbursement or payment levels for Medicare services; the provision of products or services to employer-sponsored

Table of Contents

health benefit plans; the expansion into new service areas; participation on the health insurance exchanges; the award, administration and performance of federal contracts; the administration of strategic alliances with competitors, including information sharing; and advertising, marketing and sales activities.

Each of our health plans must also be licensed by one or more agencies in the states in which they conduct business and must submit periodic filings to and respond to inquiries from such agencies. State insurance regulators may require expanded governance practices, periodic risk and solvency assessment reports, and the establishment of minimum capital or cash reserve requirements. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and

their parent holding companies or affiliates. Furthermore, our health plan operations, accounts, and other books and records are subject to examination at regular intervals by regulatory agencies, including CMS and state insurance and health and welfare departments, to assess their compliance with applicable laws and regulations. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with the laws, rules and regulations affecting our health plans, if a determination is made that we were in violation of such laws, rules or regulations with respect to one or more of our health plans, that aspect of our business could be materially adversely affected.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

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

Healthcare providers are also subject to qui tam or "whistleblower" lawsuits under the federal False Claims Act, which allows private individuals to bring actions on behalf of the government, alleging that a hospital or healthcare provider has defrauded a government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Affordable Care Act, the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, constitutes a violation of the FCA. Further, the Affordable Care Act expands the scope of the FCA to cover payments in connection with health insurance exchanges if those payments include any federal funds. Qui tam actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies. Like other companies in the healthcare industry, we are subject to qui tam actions from time to time. We are unable to predict the future impact of such actions on our business, financial condition, results of operations or cash flows. For information regarding material pending legal proceedings in which we are involved, including qui tam actions, see Note 15 to our Consolidated Financial Statements.

Table of Contents

HEALTHCARE FACILITY LICENSING REQUIREMENTS

The operation of healthcare facilities is subject to federal, state and local regulations relating to personnel, operating policies and procedures, fire prevention, rate-setting, the adequacy of medical care,

and compliance with building codes and environmental protection laws. Various licenses and permits also are required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our healthcare facilities hold all required governmental approvals, licenses and permits material to the operation of their business.

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

There has been recent increased scrutiny of hospitals' Medicare observation rates from outside auditors, government enforcement agencies and industry observers. The term "Medicare observation rate" is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In our affiliated hospitals, we use the independent, evidence-based clinical criteria developed by McKesson Corporation, commonly known as InterQual Criteria, to determine whether a patient qualifies for inpatient admission. The industry anticipates increased scrutiny and litigation risk, including government investigations and qui tam suits, related to inpatient admission decisions and the Medicare observation rate. In addition, effective October 1, 2013, CMS established a new concept, referred to as the "two-midnight rule," to guide practitioners admitting patients and contractors conducting payment reviews on when it is appropriate to admit individuals as hospital inpatients. Under the two-midnight rule, CMS has indicated that a Medicare patient should generally be admitted on an inpatient basis only when there is a reasonable expectation that the patient's care will cross two midnights, and, if not, then the patient generally should be treated as an outpatient. Following a transition period, full implementation and enforcement of the two-midnight rule began on January 1, 2016. We do not believe enforcement of the two-midnight rule will have a material impact on inpatient admission rates at our hospitals.

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

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates or determinations of need, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Our subsidiaries operate hospitals in nine states that require a form of state approval under certificate of need programs applicable to those hospitals. 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 laws and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws and regulations, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows.

ANTITRUST LAWS

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

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

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

Table of Contents

REGULATIONS AFFECTING CONIFER'S OPERATIONS

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

DEBT COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act ("FDCPA") regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC ("SOS"), are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt. In addition, the FDCPA contains various notice and disclosure requirements and imposes certain limitations on lawsuits to collect debts against consumers. Debt collection activities are also regulated at the state level. Most states have laws regulating debt collection activities in ways that are similar to, and in some cases more stringent than, the FDCPA.

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

In certain situations, the activities of SOS are also subject to the Fair Credit Reporting Act ("FCRA"). The FCRA regulates the collection, dissemination and use of consumer information, including consumer credit information. State credit reporting laws, to the extent they are not preempted by the FCRA, may also apply to SOS.

The federal Fair and Accurate Credit Transaction Act ("FACTA") requires Conifer to adopt (1) written guidance and procedures for detecting, preventing and responding appropriately to mitigate identity theft, and (2) coworker policies and procedures (including training) that address the importance of protecting non-public personal information and aid Conifer in detecting and responding to suspicious activity, including suspicious activity that may suggest a possible identity theft red flag, as appropriate.

Conifer and its subsidiaries are also subject to regulation by the Federal Trade Commission and the U.S. Consumer Financial Protection Bureau ("CFPB"). Both the FTC and the CFPB have the authority to investigate consumer complaints relating to laws such as the FDCPA, FCRA and FACTA, and to initiate enforcement actions, including actions to seek restitution and monetary penalties from, or to require changes in business practices of, regulated entities. State officials typically have authority to enforce corresponding state laws. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

PAYMENT ACTIVITY RISKS

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

transaction fees, and lose its ability to accept credit and debit card payments from customers, process electronic funds transfers, or facilitate other types of online payments.

Table of Contents

COMPLIANCE AND ETHICS

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

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

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

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

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

As part of the program, we provide annual training sessions to every employee, as well as our board of directors and certain physicians and contractors. All employees are required to report incidents that they believe in good faith may be in violation of the *Standards of Conduct*, and are encouraged to contact our 24-hour toll-free Ethics Action Line when

Table of Contents

they have questions about the standards or any ethics concerns. All reports to the Ethics Action Line are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. Incidents of alleged financial improprieties reported to the Ethics Action Line or the ethics and compliance department are communicated to the audit committee of our board of directors. Reported cases that involve a possible violation of the law or regulatory policies and procedures are referred to the ethics and compliance department for investigation. Retaliation against employees in connection with reporting ethical concerns is considered a serious violation of our *Standards of Conduct*, and, if it occurs, it will result in discipline, up to and including termination of employment.

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

INSURANCE

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

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

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

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

COMPANY INFORMATION

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

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

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

Table of Contents

EXECUTIVE OFFICERS

Information about our executive officers, as of February 22, 2016, is as follows:

Name	Position	Age
Trevor Fetter	Chairman, President and Chief Executive Officer	56
Daniel J. Cancelmi	Chief Financial Officer	53
Keith B. Pitts	Vice Chairman	58
Britt T. Reynolds	President of Hospital Operations	50
Audrey T. Andrews	Senior Vice President and General Counsel	49

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

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

certified public accountant who holds a bachelor's degree in accounting from Duquesne University in Pittsburgh. He is also a member of the American Institute of Certified Public Accountants and the Florida and Pennsylvania Institutes of Certified Public Accountants.

Mr. Pitts was appointed vice chairman following Tenet's acquisition of Vanguard Health Systems, Inc. ("Vanguard") in October 2013. He was Vanguard's vice chairman from May 2001 until the acquisition and an executive vice president from August 1999 until May 2001. Mr. Pitts also served as a director of Vanguard from August 1999 until September 2004. Before joining Vanguard, Mr. Pitts was the chairman and chief executive officer of Mariner Post-Acute Network and its predecessor, Paragon Health Network, a nursing home management company, from November 1997 until June 1999. He served as the executive vice president and chief financial officer for OrNda HealthCorp, prior to its acquisition by Tenet, from August 1992 to January 1997, and, before that, as a consultant to many healthcare organizations, including as a partner in Ernst & Young's healthcare consulting practice. Mr. Pitts is a certified public accountant who holds a bachelor's degree in business administration from the University of Florida. He is a member of the American Institute of Certified Public Accountants and the Florida Institute of Certified Public Accountants. Mr. Pitts currently serves as chair of the Federation of American Hospitals, a position he also held from 2007 to 2008.

Mr. Reynolds was appointed president of hospital operations in January 2012. From December 2008 through December 2011, he served as senior vice president and division president of Health Management Associates, Inc. (HMA), overseeing HMA's largest division, with 20 hospitals and related facilities in seven states. Prior to joining HMA, Mr. Reynolds served as a multi-facility divisional vice president of Community Health Systems, Inc. from December 2002 to December 2008, primarily in the northeast, midwest and southeast. Mr. Reynolds holds an M.B.A. from Baker University in Baldwin City, Kansas, and a bachelor's degree in psychology from the University of Louisville. He is a Fellow of the American College of Healthcare Executives.

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

Table of Contents

member of the board of directors of the Federation of American Hospitals, and is also a member of the American and Texas Bar Associations and the American Health Lawyers Association.

FORWARD-LOOKING STATEMENTS

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

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

-

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

- Adverse regulatory developments, government investigations or litigation, including any significant monetary resolution or other undesirable consequences of the Clinica de la Mama qui tam action and criminal investigation described in Note 15 to our Consolidated Financial Statements;
- Our ability to enter into managed care provider arrangements on acceptable terms;
- Cuts to Medicare and Medicaid payment rates or changes in reimbursement practices;
- Competition;
- Our success in implementing our business development plans and integrating newly acquired businesses, including our USPI joint venture;
- Our ability to hire and retain qualified personnel, especially healthcare professionals;
- The availability and terms of capital to fund the expansion of our business;
- Our ability to continue to expand and realize earnings contributions from Conifer's revenue cycle management, healthcare information management, capitation management and patient communications services businesses;
- Our ability to identify and execute on measures designed to save or control costs or streamline operations;
- The impact of our significant indebtedness;
- Our success in completing recently announced corporate development transactions;
- Our success in operating our health plans and accountable care networks; and
- Other factors and risks referenced in this report and our other public filings.

Table of Contents

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

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

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

ITEM 1A. RISK FACTORS

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

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

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

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

Table of Contents

- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the enhanced program integrity and fraud and abuse provisions lead to a greater number of civil or criminal actions or impact Medicare and Medicaid payments to us; and
- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

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

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are fully implemented;
- whether future reductions required by the ACA will be changed by statute prior to becoming effective;
- the size of the annual productivity adjustment to the market basket;
- the reductions to Medicaid DSH payments commencing in FFY 2018;
- what the losses in revenues, if any, will be from the ACA's quality initiatives;
- how successful accountable care networks and other pilot programs in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement; and
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs.

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

In general, there is still uncertainty with respect to the positive and negative effects the Affordable Care Act may have on reimbursement, utilization and the future design of provider networks and insurance plans (including pricing, provider participation, coverage, co-pays and deductibles), and the multiple models that attempt to forecast those effects may differ materially from our expectations. We are unable to predict the net effect of the ACA on our future revenues and operations at this time due to uncertainty regarding the ultimate number of uninsured individuals who will obtain and retain insurance coverage, uncertainty regarding future negotiations with payers, uncertainty regarding Medicaid expansion, and gradual and, in some cases, delayed implementation of certain provisions of the law. We also cannot predict the outcome of continuing legal challenges to certain provisions of the ACA or what action, if any, Congress might take with respect to the ACA. Any action that negatively impacts the number of individuals who have health insurance coverage could have a material adverse effect on our results of operations and cash flows.

Table of Contents

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

We currently have thousands of managed care contracts with various HMOs and PPOs. The amount of our managed care net patient revenues during the year ended December 31, 2015 was $10.6 billion, which represented approximately 60% of our total net patient revenues before provision for doubtful accounts. Approximately 62% of our managed care net patient revenues for the year ended December 31, 2015 was derived from our top ten managed care payers. In the year ended December 31, 2015, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. In addition, at December 31, 2015, approximately 59% of our net accounts receivable related to continuing operations were due from managed care payers.

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

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

For the year ended December 31, 2015, approximately 20.4% of our net patient revenues before provision for doubtful accounts for our Hospital Operations and other segment were related to the Medicare program, and approximately 8.7% of our net patient revenues before provision for doubtful accounts for our Hospital Operations and other segment were related to various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. In addition to the changes affected by the Affordable Care Act, the Medicare and Medicaid programs are subject to: other statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from government programs could be exacerbated if we are not able to manage our operating costs effectively.

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

Table of Contents

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

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

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

The Secretary of HHS also recently announced a goal of tying 30% of traditional Medicare payments to quality or value through alternative payment models or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018. In furtherance of this goal, in November 2015, CMS finalized a new five-year demonstration project, called the Comprehensive Care for Joint Replacement ("CJR") model, set to begin on April 1, 2016, which will hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements (and other major leg procedures) from surgery through recovery. As a result, the hospital in which a lower extremity joint replacement ("LEJR") procedure takes place will be held financially accountable for quality and costs for the entire episode of care, from the date of surgery through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Through the CJR payment model, beginning in 2017, participating hospitals in 67 geographic areas across the country – including 20 of our acute care hospitals and four short-stay surgical facilities operated by our USPI joint venture – will be eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria. We anticipate that CMS will develop additional, similar, alternative payment models for other conditions in the future.

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 this trend 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 under new value-based purchasing and alternative payment models.

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

The healthcare business is highly competitive, and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities (1) are more established or newer than ours, (2) may offer a broader array of services to patients and physicians than ours, and (3) may have larger

Table of Contents

or more specialized medical staffs to admit and refer patients, among other things. Furthermore, healthcare consumers are now able to access hospital performance data on quality measures and patient satisfaction, as well as standard charges for services, to compare competing providers; if any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or patient satisfaction surveys, or if our standard charges are higher than our competitors, we may attract fewer patients. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

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

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, pursuant to the Affordable Care Act, the OIG is permitted to suspend Medicare and Medicaid payments to a provider of services "pending an investigation of a credible allegation of fraud." The potential consequences for violating such laws, rules or regulations include reimbursement of government program payments, the assessment of civil monetary penalties, including treble damages, fines, which could be significant, exclusion from participation in federal healthcare programs, or criminal sanctions against current or former employees, any of which could have a material adverse effect on our business, financial condition or cash flows. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on the value of our common stock and our business reputation could suffer.

Furthermore, healthcare, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local healthcare regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively affecting healthcare providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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

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

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

Table of Contents

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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

The success of our business depends in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and who affiliate with us and use our facilities as an extension of their practices. Although we operate physician practices and, where permitted by law, employ physicians, physicians are often not employees of the hospitals or surgery centers at which they practice. Furthermore, members of the medical staffs of our hospitals also often serve on the medical staffs of hospitals we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing hospitals at any time. 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. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

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

Our new USPI joint venture and our recent hospital-based joint ventures depend in part on the efforts, reputations and success of health system partners and the strength of our relationships with those health systems. Our joint ventures could be adversely affected by any damage to those health systems'

reputations or to our relationships with them. In many cases, our joint venture agreements are structured to comply with current IRS revenue rulings, as well as case law, relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with health system partners. If we are unable to maintain existing arrangements on favorable terms or enter into relationships with additional health system partners, we may be unable to implement our business strategies for our joint ventures successfully.

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

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

Table of Contents

Increased labor union activity is another factor that could adversely affect our labor costs. At December 31, 2015, approximately 20% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 37 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating first contracts at two of our hospitals where employees selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation; to the extent a greater portion of our employee base unionizes, it is possible our labor costs could increase materially.

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

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

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

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

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. However, the market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market (including software vendors and other technology-supported revenue cycle management outsourcing companies, traditional consultants and information technology outsourcing firms), as well as from the staffs of hospitals and other healthcare providers who handle these processes internally. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Moreover, existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

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

Conifer and its subsidiaries are subject to numerous federal, state and local consumer financial, debt collection and credit reporting laws, rules and regulations. Regulations governing debt collection are subject to changing

Table of Contents

interpretations that may be inconsistent among different jurisdictions. In addition, a regulatory determination made by, or a settlement or consent decree entered into with, one regulatory agency, such as the Consumer Financial Protection Bureau, may not be binding upon, or preclude, investigations or regulatory actions by state or local agencies. Conifer's failure to comply with consumer financial, debt collection and credit reporting requirements could result in, among other things, the issuance of cease and desist orders (which can include orders for restitution or rescission of contracts, as well as other kinds of affirmative relief), the imposition of fines or refunds, and other civil and criminal penalties, some of which could be significant in the case of knowing or reckless violations. In addition, Conifer's failure to comply with the laws and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its customers, or give customers the right to terminate Conifer's services agreements with them, among other things, any of which could have an adverse effect on Conifer's business. Furthermore, if Conifer or its subsidiaries become subject to fines or other penalties, it could harm Conifer's reputation, thereby making it more difficult for Conifer to retain existing customers or attract new customers

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

As a provider of healthcare services, information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive and confidential data, including protected health information, personally identifiable information of our patients and employees, and our proprietary and confidential business performance data. We utilize electronic health records and other health information technology, along with additional technology systems, in connection with our operations, including for, among other things, billing, supply chain and labor management. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the security and availability of the data we process, transmit and store, our information technology and infrastructure have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. While we are not aware of having experienced a material breach of cybersecurity, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we may be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, or invest in new technology designed to mitigate security risks. Third parties to whom we outsource certain of our functions, or with whom our systems interface, are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting one of our third-party service providers or partners could harm our business even if we do not control the service that is attacked. Further, successful cyber-attacks at other healthcare services companies, whether or not we are impacted, could lead to a general loss of customer confidence in our industry that could negatively affect us, including harming the market perception of the effectiveness of our security measures or of the healthcare industry in general, which could result in reduced use of our services. Though we have insurance against some cyber-risks and attacks, it may not be sufficient to offset the impact of a material loss event.

Furthermore, our networks and technology systems are subject to disruption due to events such as a major earthquake, fire, telecommunications failure, terrorist attack or other catastrophic event. Any such breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact our ability to conduct normal business operations (including the collection of revenues), and could result in potential liability under privacy, security, consumer protection or other applicable laws, regulatory penalties, negative publicity and damage to our reputation, any of which could have a material adverse effect on our business, financial position, results of operations or cash flows.

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

We have completed, or have announced plans to complete, a number of acquisitions, divestitures, joint ventures and strategic alliances as part of our business strategy, and we expect to enter into similar transactions in the future. We cannot provide any assurances that these transactions will achieve their business goals or the cost and service synergies we expect. In particular, our USPI joint venture represents an increased strategic focus on ambulatory and short-stay surgical

Table of Contents

facilities, as well as related imaging services businesses, and we cannot provide any assurances that this strategy will be successful. Furthermore, with respect to acquisitions, we may not be able to identify suitable candidates, consummate transactions on terms that are favorable to us, or achieve expected returns, synergies or other benefits in a timely manner or at all. With respect to proposed divestitures of assets or businesses, we may encounter difficulties in finding acquirers or alternative exit strategies on terms that are favorable to us, which could delay the accomplishment of our strategic objectives. In addition, our divestiture activities have required, and may in the future require, us to recognize

impairment charges or to agree to contractual restrictions that limit our ability to reenter the applicable market, which may be material.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On June 16, 2015, we entered into a Contribution and Purchase Agreement (the "Contribution and Purchase Agreement") with USPI Group Holdings, Inc. ("USPI Holdings"), Ulysses JV Holding I L.P. ("Ulysses Holding I"), Ulysses JV Holding II L.P. ("Ulysses Holding II" and, together with Ulysses Holding I, the "USPI LPs"), and the newly formed USPI Holding Company, Inc., our USPI joint venture. USPI Holdings is the parent company of United Surgical Partners International, Inc. USPI Holdings, through USPI and its other subsidiaries, is engaged in the business of owning and managing ambulatory surgery centers, surgical hospitals and related businesses. Pursuant to the terms of the Contribution and Purchase Agreement, at the closing, the USPI LPs collectively sold and contributed 100% of the equity interests of USPI Holdings to the USPI joint venture in exchange for certain shares of common stock of the USPI joint venture (the "USPI Contribution"), and we sold and contributed certain of our equity interests and other assets that comprised a portion of our ambulatory surgery center and imaging center business to the USPI joint venture (the "Tenet Contribution" and, together with the USPI Contribution, the "Contributions").We also purchased certain shares of the USPI joint venture (the "Purchase" and, together with the Contributions, the "Contribution and Purchase Transactions") from the USPI LPs such that, after giving effect to the Contribution and Purchase Transactions, we owned 50.1% and the USPI LPs, in the aggregate, owned 49.9% of the fully diluted equity interests of the USPI joint venture. In December 2015, the USPI LPs sold 3.01% of the fully diluted equity interests of the USPI joint venture to Baylor University Medical Center.

In connection with the Contribution and Purchase Agreement, we, the USPI LPs and the USPI joint venture entered into a stockholders agreement pursuant to which we and the USPI LPs agreed to certain rights and obligations with respect to the governance of the USPI joint venture. In addition, we entered into a put/call agreement (the "Put/Call Agreement") that contains put and call options with respect to the equity interests in the USPI joint venture held by the USPI LPs. Each year starting in 2016, the USPI LPs must put to us at least 12.5%, and may put up to 25%, of the USPI joint venture shares held by them immediately after the closing of the Contribution and Purchase Agreement. In each year that the USPI LPs are to deliver a put and do not put the full 25% of USPI joint venture shares allowable, we may call the difference between the number of USPI joint venture shares the USPI LPs put and the maximum number of USPI joint venture shares the USPI LPs could have put that year. In addition, the Put/Call Agreement contains certain other call options pursuant to which we will have the

ability to acquire all of the ownership interests held by the USPI LPs by 2020. In the event of a put by the USPI LPs, we will have the ability to choose whether to settle the purchase price in cash or shares

Table of Contents

of our common stock and, in the event of a call by us, the USPI LPs will have the ability to choose whether to settle the purchase price in cash or shares of our common stock.

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

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

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

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

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

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

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

incur additional restructuring charges. Future restructuring of our operating structure that changes our goodwill reporting units could also result in future impairments of our goodwill. Any such charges could negatively impact our results of operations.

Table of Contents

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, 2015, we had approximately $14.4 billion of total long-term debt, as well as approximately $110 million in standby letters of credit outstanding in the aggregate, under our senior secured revolving credit facility ("Credit Agreement") and our letter of credit facility agreement ("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.

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

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

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

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

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

In addition, our ability to meet our debt service obligations is dependent upon the operating results of our subsidiaries and their ability to pay dividends or make other payments or advances to us. We hold most of our assets at, and conduct most 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.

Table of Contents

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

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

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

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

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

In addition, so long as any obligation or commitment is outstanding under our Credit Agreement and LC Facility, the terms of such facilities require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. Our ability to meet these restrictive covenants and financial ratio may be affected by events beyond our control, and we cannot assure you that we will meet those tests. These restrictions could limit our ability to obtain future financing, make acquisitions or needed capital expenditures, withstand economic downturns in our business or the economy in general, conduct operations or otherwise take advantage of business

opportunities that may arise. In addition, a breach of any of these covenants could cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

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

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

Our Credit Agreement provides for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Based on our eligible receivables, approximately $995 million was available for borrowing under the Credit Agreement at December 31, 2015. Our LC Facility provides for the issuance of

Table of Contents

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, 2015, we had approximately $105 million of standby letters of credit outstanding under the LC Facility. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

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

At December 31, 2015, we had federal net operating loss ("NOL") carryforwards of approximately $1.8 billion pretax available to offset future taxable income. These NOL carryforwards will expire in the years 2024 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.

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

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

Table of Contents

PART II.

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

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

	High	Low
Year Ended December 31, 2015		
First Quarter	$ 52.69	$ 41.47
Second Quarter	59.21	46.33
Third Quarter	60.93	35.76
Fourth Quarter	39.75	26.60
Year Ended December 31, 2014		
First Quarter	$ 48.70	$ 38.40
Second Quarter	50.25	37.95
Third Quarter	63.61	44.20
Fourth Quarter	59.65	46.01

On February 12, 2016, the last reported sales price of our common stock on the NYSE composite tape was $24.00 per share. As of that date, there were 4,414 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

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

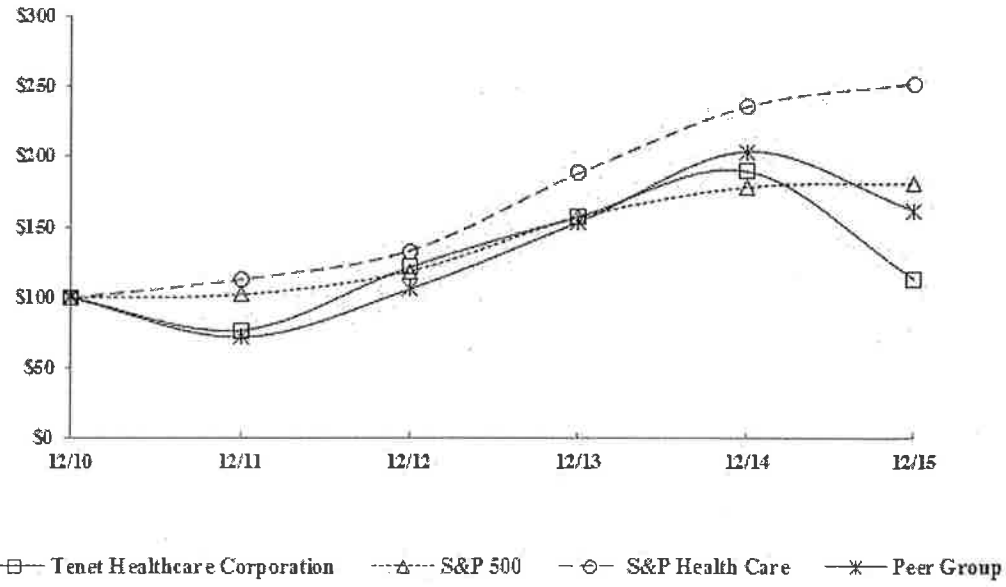
Equity Compensation. Refer to Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of Part III of this report for information regarding securities authorized for issuance under our equity compensation plans.

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to three indices, each of which includes us. The Standard & Poor's 500 Stock Index includes 500 companies representing all major industries. The Standard & Poor's Health Care Composite Index is a group of 56 companies involved in a variety of healthcare-related businesses. Because the Standard & Poor's Health Care Composite Index is heavily weighted by pharmaceutical and medical device companies, we believe that at times it may be less useful than the Hospital Management Peer Group Index included below. We compiled this Peer Group Index by selecting publicly traded companies that have as their primary business the management of acute care hospitals and that have been in business for all five of the years shown. These companies are: Community Health Systems, Inc. (CYH), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS).

Table of Contents

Performance data assumes that $100.00 was invested on December 31, 2010 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Stock price performance shown in the graph is not necessarily indicative of future stock price performance.

COMPARISON OF FIVE-YEAR CUMULATIVE TOTAL RETURN



	12/10	12/11	12/12	12/13	12/14	12/15
Tenet Healthcare Corporation	$ 100.00	$ 76.68	$ 121.34	$ 157.40	$ 189.35	$ 113.23
S&P 500	$ 100.00	$ 102.11	$ 118.45	$ 156.82	$ 178.29	$ 180.75
S&P Health Care	$ 100.00	$ 112.73	$ 132.90	$ 188.00	$ 235.63	$ 251.87
Peer Group	$ 100.00	$ 71.77	$ 105.66	$ 153.32	$ 203.42	$ 161.65

Repurchase of Common Stock. In November 2015, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expires in December 2016. Under the program, shares may be purchased in the open

market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations. The program may be suspended for periods or discontinued at any time. The timing and amount of repurchase transactions will be based on an evaluation of market conditions, share purchase prices, the timing of divestiture proceeds and other factors. Purchases during the year ended December 31, 2015 are shown in the table in Note 2 to our Consolidated Financial Statements, which table is incorporated by reference.

Table of Contents

ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2011 through 2015. Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into our new USPI joint venture. The table below includes USPI results in the 2015 column for the post-acquisition period only. We acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013. The 2013 columns in the tables below include results of operations for Vanguard and its consolidated subsidiaries for the three months ended December 31 2013 only. All amounts related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for the one-for-four reverse stock split we announced on October 1, 2012. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2015	2014	2013	2012	2011
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts	$ 20,111	$ 17,908	$ 12,059	$ 9,896	$ 9,363
Less: Provision for doubtful accounts	1,477	1,305	972	785	717
Net operating revenues	**18,634**	**16,603**	**11,087**	**9,111**	**8,646**
Equity in earnings of unconsolidated affiliates	**99**	**12**	**15**	**8**	**8**
Operating expenses:					
Salaries, wages and benefits	9,011	8,023	5,371	4,257	4,015
Supplies	2,963	2,630	1,784	1,552	1,548
Other operating expenses, net	4,555	4,114	2,701	2,147	2,020
Electronic health record incentives	(72)	(104)	(96)	(40)	(55)
Depreciation and amortization	797	849	545	430	398
Impairment and restructuring charges, and acquisition-related costs	318	153	103	19	20
Litigation and investigation costs, net of insurance recoveries	291	25	31	5	55
Gains on sales, consolidation and deconsolidation of facilities	(186)	—	—	—	—
Operating income	**1,056**	**925**	**663**	**749**	**653**
Interest expense	(912)	(754)	(474)	(412)	(375)
Loss from early extinguishment of debt	(1)	(24)	(348)	(4)	(117)
Investment earnings	1	—	1	1	3
Income (loss) from continuing operations, before income taxes	**144**	**147**	**(158)**	**334**	**164**
Income tax benefit (expense)	(68)	(49)	65	(125)	(61)
	$ 76	$ 98	$ (93)	$ 209	$ 103

Income (loss) from continuing operations, before discontinued operations and cumulative effect of change in accounting principle					
Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations[1]	**$ (1.43)**	**$ 0.35**	**$ (1.21)**	**$ 1.77**	**$ 0.58**
Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations[1]	**$ (1.43)**	**$ 0.34**	**$ (1.21)**	**$ 1.70**	**$ 0.56**

(1) Net income attributable to noncontrolling interest from continuing operations was $218 million, $64 million, $30 million, $13 million and $11 million for the years ended December 31, 2015, 2014, 2013, 2012 and 2011, respectively.

Table of Contents

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

BALANCE SHEET DATA

	December 31,				
	2015	2014	2013	2012	2011
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 863	$ 393	$ 599	$ 918	$ 542
Total assets	23,682	17,951	16,450	9,044	8,462
Long-term debt, net of current portion	14,383	11,505	10,696	5,158	4,294
Redeemable noncontrolling interest in equity of consolidated subsidiaries	2,266	401	340	16	16
Noncontrolling interests	267	134	123	75	69

Total equity	958	785	878	1,218	1,492

CASH FLOW DATA

	Years Ended December 31,				
	2015	2014	2013	2012	2011
	(In Millions)				
Net cash provided by operating activities	$ 1,026	$ 687	$ 589	$ 593	$ 497
Net cash used in investing activities	(1,317)	(1,322)	(2,164)	(662)	(503)
Net cash provided by (used in) financing activities	454	715	1,324	320	(286)

Table of Contents

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, urgent care centers, freestanding emergency departments, physician practices and health plans. Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI joint venture"), in which we acquired a majority interest on June 16, 2015, and European Surgical Partners Ltd. ("Aspen") facilities, which we also acquired on June 16, 2015. Our USPI joint venture has interests in 249 ambulatory surgery centers, 20 short-stay surgical hospitals, 20 imaging centers and 35 urgent care centers in 28 states. Aspen includes nine private hospitals and clinics in the United Kingdom. We also operate revenue cycle management, patient communications and engagement services, and management services businesses through our Conifer Holdings, Inc. ("Conifer") subsidiary, which is a separate reportable business segment. MD&A, which should be read in conjunction with the accompanying Consolidated Financial Statements, includes the following sections:

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

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 48 hospitals operated throughout the years ended December 31, 2015, 2014 and 2013, (ii) Vanguard and its consolidated subsidiaries, which we acquired effective October 1, 2013, but only for the period from the date of acquisition through December 31, 2015 (iii) Texas Regional Medical Center at Sunnyvale ("TRMC"), in which we acquired a majority interest on June 3, 2014, (iv) Resolute Health Hospital, which we opened on June 24, 2014, (v) Emanuel Medical Center, which we acquired on August 1, 2014, (vi) our USPI joint

venture, in which we acquired a majority interest on June 16, 2015, (vii) Aspen, which we also acquired on June 16, 2015, (viii) Hi-Desert Medical Center, which we began operating on July 15, 2015, (ix) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (x) Saint Louis University Hospital ("SLUH"), which we sold on August 31, 2015, (xi) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and (xii) DMC Surgery Hospital, which we closed in October 2015, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to December 31, 2015, 2014 and 2013, as applicable. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. Certain previously reported information, primarily related to our freestanding ambulatory surgery and imaging center assets that were contributed to the USPI joint venture, has been reclassified to conform to the current-year presentation. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Welsh Carson Put Notices—In January 2016, subsidiaries of Welsh, Carson, Anderson & Stowe delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to the Put/Call Agreement, as defined in Note 16 to our Consolidated Financial Statements. The estimated amount we will pay to repurchase these shares is $127 million.

Table of Contents

Joint Ventures with Baylor Scott & White Health—Effective January 1, 2016, we formed two joint ventures with Baylor Scott & White Health ("BSW") involving the ownership and operation of Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center and Texas Regional Medical Center at Sunnyvale (collectively, "our North Texas hospitals") – which were operated by certain of our subsidiaries – and Baylor Medical Center at Garland – which was owned and operated by BSW, which will hold a majority ownership interest in the joint ventures. The transactions closed on December 31, 2015 at a net transaction price of approximately $288 million, and we recorded a gain on deconsolidation of these facilities of approximately $151 million. We also recorded an equity investment in the new joint ventures of approximately $164 million, which included $11 million of cash contributed at closing.

Sale of North Carolina Hospitals—Also effective January 1, 2016, we completed the sale of our 137-bed Central Carolina Hospital in Sanford, North Carolina and our 355-bed Frye Regional Medical Center in Hickory, North Carolina, as well as 19 physician practices, at a transaction price of approximately $191 million, excluding working capital and subject to customary purchase price adjustments. As a result of this transaction, we recorded a gain on sale of approximately $3 million at December 31, 2015, the date the transaction closed.

Definitive Agreement to Sell Atlanta-Area Hospitals and Related Operations—In December 2015, we announced a definitive agreement for the sale and management of our Atlanta-area hospitals – Atlanta Medical Center and its South Campus, North Fulton Hospital, Spalding Regional Hospital and Sylvan Grove Hospital – as well as 26 physician clinics. This sale, which is subject to customary closing conditions, including regulatory approvals, is expected to be completed as early as the end of the first quarter of 2016.

STRATEGIES AND TRENDS

We are committed to providing the communities we serve with high quality, cost-effective healthcare while growing our business, increasing our profitability and creating long-term value for our

shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed below.

Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to healthcare providers through Conifer. With respect to our hospitals, ambulatory care centers and other outpatient businesses, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology, to recruit and retain physicians, and to negotiate competitive contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We are continuing to make significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. In addition, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay and reductions in readmissions for hospitalized patients.

Development Strategies—We remain focused on opportunities to increase our hospital and outpatient revenues, and to expand our Conifer services business, through organic growth, corporate development activities and strategic partnerships.

From time to time, we build new facilities, make acquisitions of healthcare assets and companies, and enter into joint venture arrangements or affiliations with healthcare businesses in markets where we believe our operating strategies can improve performance and create shareholder value. In June 2015, we completed the transaction that combined our

Table of Contents

freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets into a new joint venture owned by us and Welsh, Carson, Anderson & Stowe, a private equity firm that specializes in healthcare investments. At December 31, 2015, the joint venture had interests in 249 ambulatory surgery centers, 20 short-stay surgical hospitals, 20 imaging centers and 35 urgent care centers in 28 states. Moreover, we significantly increased the number of our not-for-profit partners through USPI and now have relationships with more than 50 leading healthcare systems across the country.

Also in June 2015, we acquired Aspen Healthcare in the United Kingdom. Although the U.K. provides government-funded healthcare to all of its residents through the National Health Service, the demand for healthcare services exceeds the public system's capacity. Aspen's four acute care hospitals, one cancer center and four outpatient facilities offer patients a complete range of private healthcare and clinical services in a growing market.

In addition, in July 2015, we began operating Hi-Desert Medical Center and its related healthcare facilities in Joshua Tree, California under a long-term lease agreement and, in August 2015, we formed a new joint venture with Dignity Health and Ascension Health to own and operate Carondelet Health Network based in Tucson, Arizona. In October 2015, we formed a new joint venture with Baptist Health System to own and operate a healthcare network serving Birmingham and central Alabama; we own a majority interest in the joint venture, and we manage the network's five hospitals and related businesses. Effective January 1, 2016, we formed two joint ventures with Baylor Scott & White Health

involving the ownership and operation of five North Texas hospitals: Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center, and TRMC – which were operated by certain of our subsidiaries – and Baylor Medical Center at Garland – which was operated by BSW. The joint ventures will focus on delivering integrated, value-based care primarily to select communities in Rockwall, Collin and Dallas counties. BSW holds a majority ownership interest in the joint ventures.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the three months ended December 31, 2015, we derived approximately 42% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. The facilities in our USPI joint venture specialize in non-emergency surgical cases. Due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable in a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. In addition, we have continued growing our urgent care business through our USPI joint venture's acquisition of CareSpot Express Healthcare, which added 35 urgent care centers in Florida and Tennessee to its portfolio of outpatient centers, as part of our broader strategy to offer more services to patients and to expand into faster-growing, less capital intensive, higher-margin businesses. Furthermore, we continually evaluate joint venture opportunities with other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. Conifer provides services to more than 800 Tenet and non-Tenet hospital and other clients nationwide. This business has generated high margins and improved our overall results of operations in recent quarters. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals and independent physician associations, clients for these services include health plans, self-insured employers, government agencies and other entities. We also remain focused on developing, acquiring or entering into joint venture arrangements to establish new capabilities at Conifer. In October 2014, Conifer acquired SPi Healthcare, which provides revenue cycle solutions for independent and provider-owned physician practices, thereby increasing our ability to offer enterprise solutions to Conifer's customers. In January 2015, Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032.

Realizing HIT Incentive Payments and Other Benefits—Beginning in the year ended December 31, 2011, we began achieving compliance with certain of the health information technology ("HIT") requirements under the American Recovery and Reinvestment Act of 2009 ("ARRA"). During the years ended December 31, 2015 and 2014, we recognized approximately $72 million and $104 million, respectively, of Medicare and Medicaid electronic health record ("EHR")

Table of Contents

ARRA incentives. These incentives partially offset the operating expenses and capital costs we have incurred and continue to incur to invest in HIT systems. We expect to recognize additional incentives in the future. Furthermore, we believe that the operational benefits of HIT, including improved clinical outcomes and increased operating efficiencies, will contribute to our long-term ability to grow our business.

General Economic Conditions—We believe that high unemployment rates in some of the markets our hospitals serve and other adverse economic conditions have had a negative impact on our bad debt expense levels and payer mix. However, as the economy recovers, we expect to experience improvements in these metrics relative to recent levels. We believe our volumes were positively impacted in the year ended December 31, 2015 by incremental market share we generated through

improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. We believe our patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher patient co-pays and deductibles, and demographic trends. In addition, in several markets, we have formed clinically integrated organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of Affordable Care Act—We anticipate that we will continue to benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") that have extended insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by governmental payers, we began to receive reimbursement for caring for previously uninsured and underinsured patients in 2014. Through collaborative efforts with local community organizations, we launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans. At December 31, 2015, we operated hospitals in six of the states (Arizona, California, Illinois, Massachusetts, Michigan and Pennsylvania) that have expanded their Medicaid programs.

Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is important that we make steady and measurable progress in successfully integrating acquired businesses and new joint ventures into our business processes, as appropriate. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

RESULTS OF OPERATIONS—OVERVIEW

We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2015 and 2014 on both a continuing operations and a same-hospital operations basis.

Selected Operating Statistics for All Continuing Operations Hospitals— The following table shows certain selected operating statistics for our continuing operations, which includes the results of (i) our same 75 hospitals and six health plans operated throughout the three months ended December 31, 2015 and 2014, (ii) TRMC, in which we acquired a majority interest on June 3, 2014, (iii) Resolute Health Hospital, which we opened on June 24, 2014, (iv) Emanuel Medical Center, which we acquired on August 1, 2014, (v) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (vi) Aspen, which we also acquired on June 16, 2015, (vii) Hi-Desert Medical Center, which we began operating on July 15, 2015, (viii) our Carondelet Heath Network joint venture, which we acquired a majority interest on August 31, 2015, (xi) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and (xii) DMC Surgery Hospital, which we closed in October 2015, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to December 31, 2015 and 2014, as applicable. We believe

this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses.

Selected Operating Statistics	Continuing Operations Three Months Ended December 31, 2015	2014	Increase (Decrease)
Hospital Operations and other			
Total admissions	211,991	202,337	4.8 %
Adjusted patient admissions[1]	371,994	344,857	7.9 %
Paying admissions (excludes charity and uninsured)	200,462	191,105	4.9 %
Charity and uninsured admissions	11,529	11,232	2.6 %
Emergency department visits	778,148	737,680	5.5 %
Total surgeries	138,264	128,050	8.0 %
Patient days — total	983,856	937,803	4.9 %
Adjusted patient days[1]	1,710,620	1,578,854	8.3 %
Average length of stay (days)	4.64	4.63	0.2 %
Number of hospitals (at end of period)	86	80	6 [3]
Average licensed beds	22,549	20,805	8.4 %
Utilization of licensed beds[2]	47.4 %	49.0 %	(1.6)%[3]
Total visits	2,198,005	1,995,237	10.2 %
Paying visits (excludes charity and uninsured)	2,024,725	1,829,872	10.6 %
Charity and uninsured visits	173,280	165,365	4.8 %
Ambulatory Care			
Total consolidated facilities (at end of period)	192	60	132 [3]
Total cases	289,033	148,019	95.3 %

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.
(3) The change is the difference between the 2015 and 2014 amounts shown.

Total admissions increased by 9,654, or 4.8%, in the three months ended December 31, 2015 compared to the three months ended December 31, 2014. Total surgeries increased by 8.0% in the three months ended December 31, 2015 compared to the same period in 2014. Our emergency department visits increased 5.5% in the three months ended December 31, 2015 compared to the same period in the prior year. Our volumes were positively impacted by acquisitions, as well as, we believe, incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy. Charity and uninsured admissions and outpatient visits increased 2.6% and 4.8%, respectively, in the three months ended December 31, 2015 compared to the three months ended December 31, 2014 primarily due to acquisitions.

Revenues	Continuing Operations Three Months Ended December 31, 2015	2014	Increase (Decrease)
Net operating revenues before provision for doubtful accounts	$ 5,417	$ 4,821	12.4 %
Hospital Operations and other			
Revenues from charity and the uninsured	$ 267	$ 265	0.8 %
Net inpatient revenues[1]	$ 2,736	$ 2,719	0.6 %
Net outpatient revenues[1]	$ 1,616	$ 1,448	11.6 %
Ambulatory Care revenues	$ 397	$ 90	341.1 %
Conifer revenues	$ 384	$ 327	17.4 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $96 million and $99 million for the three months ended December 31, 2015 and 2014, respectively. Net outpatient revenues include self-pay revenues of $171 million and $166 million for the three months ended December 31, 2015 and 2014, respectively.

Table of Contents

Net operating revenues before provision for doubtful accounts increased by $596 million, or 12.4%, in the three months ended December 31, 2015 compared to the same period in 2014, primarily due to acquisitions, increases in our outpatient volumes and improved managed care pricing, partially offset by decreased net revenues related to the timing of the approval of the California provider fee program that was approved in the three months ended December 31, 2014, which resulted in a full year of program revenue being recorded in the fourth quarter of 2014. Net operating revenues before provision for doubtful accounts in the three months ended December 31, 2015 included $49 million of net revenues from the California provider fee program compared to $165 million during the three months ended December 31, 2014

	Continuing Operations Three Months Ended December 31,		
Provision for Doubtful Accounts	**2015**	**2014**	**Increase (Decrease)**
Provision for doubtful accounts	$ 391	$ 356	9.8 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.2 %	7.4 %	% (0.2)[1]

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

Provision for doubtful accounts increased by $35 million, or 9.8%, in the three months ended December 31, 2015 compared to the same period in 2014, and provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.2% and 7.4% for the three months ended December 31, 2015 and 2014, respectively. The increase in the provision for doubtful accounts primarily related to the impact of the $596 million increase in our net operating revenues before provision for doubtful accounts, including a $2 million increase in revenues from charity, and a greater amount of patient co-pays and deductibles. Our accounts receivable days outstanding ("AR Days") from continuing operations were 49.5 days at both December 31, 2015 and 2014, within our target of less than 55 days.

	Continuing Operations Three Months Ended December 31,		
Selected Operating Expenses	**2015**	**2014**	**Increase (Decrease)**
Hospital Operations and other			
Salaries, wages and benefits	$ 2,075	$ 1,898	9.3 %
Supplies	738	670	10.1 %
Other operating expenses	1,067	962	10.9 %
Total	$ 3,880	$ 3,530	9.9 %
Ambulatory Care			
Salaries, wages and benefits	$ 130	$ 24	441.7 %
Supplies	79	18	338.9 %
Other operating expenses	78	19	310.5 %
Total	$ 287	$ 61	370.5 %
Conifer			
Salaries, wages and benefits	$ 238	$ 196	21.4 %
Other operating expenses	85	67	26.9 %
Total	$ 323	$ 263	22.8 %
Total			
Salaries, wages and benefits	$ 2,443	$ 2,118	15.3 %
Supplies	817	688	18.8 %
Other operating expenses	1,230	1,048	17.4 %
Total	$ 4,490	$ 3,854	16.5 %
Rent/lease expense[1]			
Hospital Operations and other	$ 67	$ 55	21.8 %
Conifer	4	3	33.3 %
Ambulatory Care	15	6	150.0 %
Total	$ 86	$ 64	34.4 %

(1) Included in other operating expenses.

Table of Contents

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended December 31, 2015	2014	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits per adjusted patient admission[1]	$ 5,577	$ 5,550	0.5 %
Supplies per adjusted patient admission[1]	1,984	1,943	2.1 %
Other operating expenses per adjusted patient admission[1]	2,890	2,810	2.8 %
Total per adjusted patient admission	$10,451	$10,303	1.4 %

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

Salaries, wages and benefits per adjusted patient admission increased 0.5% in the three months ended December 31, 2015 compared to the same period in 2014. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees and increased employee health benefits costs, partially offset by a decline in contract labor costs, in the three months ended December 31, 2015 compared to the three months ended December 31, 2014.

Supplies expense per adjusted patient admission increased 2.1% in the three months ended December 31, 2015 compared to the three months ended December 31, 2014. The change in supplies expense was primarily attributable to higher costs for pharmaceuticals and cardiology supplies, and volume growth in our supply-intensive surgical services.

Other operating expenses per adjusted patient admission increased by 2.8% in the three months ended December 31, 2015 compared to the three months ended December 31, 2014. This increase is due to higher contracted services and medical fees primarily related to a greater number of employed and contracted physicians, as well as increased malpractice expense. Malpractice expense was $20 million higher in the 2015 period compared to the 2014 period due to incremental patient volumes and unfavorable adjustments to settle various cases to mitigate the risk of protracted litigation. The 2015 period included a favorable adjustment of approximately $7 million due to a 34 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a unfavorable adjustment of approximately $4 million as a result of a 25 basis point decrease in the interest rate in the 2014 period.

The table below shows the pre-tax and after-tax impact on continuing operations for the three months and years ended December 31, 2015 and 2014 of the following items:

	Three Months Ended December 31, 2015	2014	Years Ended December 31, 2015	2014
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (52)	$ (63)	$ (318)	$ (153)
Litigation and investigation costs	(224)	(6)	(291)	(25)
Loss from early extinguishment of debt	(1)	—	(1)	(24)
Gains on sales, consolidation and deconsolidation of facilities	186	—	186	—
Pre-tax impact	$ (91)	$ (69)	$ (424)	$ (202)
Total after-tax impact	$ (135)	$ (43)	$ (350)	$ (111)
Diluted per-share impact of above items	$ (1.36)	$ (0.42)	$(3.48)	$(1.11)
Diluted earnings (loss) per share, including above items	$ (1.01)	$ 0.61	$(1.43)	$ 0.34

Table of Contents

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $356 million at December 31, 2015 compared to $450 million at September 30, 2015.

Significant cash flow items in the three months ended December 31, 2015 included:

- Net cash provided by operating activities before interest, taxes and restructuring charges, acquisition-related costs, and litigation costs and settlements of $576 million;
- Capital expenditures of $276 million;
- Purchases of businesses and equity interests of $336 million;
- Interest payments of $340 million;
- $110 million of net repayment for revolving credit facility; and
- $522 million for proceeds from sales of facilities.

Net cash provided by operating activities was $1.026 billion in the year ended December 31, 2015 compared to $687 million in the year ended December 31, 2014. Key positive and negative factors contributing to the change between the 2015 and 2014 periods include the following:

- Increased income from continuing operations before income taxes of $324 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the year ended December 31, 2015 compared to the year ended December 31, 2014;
- $436 million less cash used by the change in accounts receivable, net of provision of doubtful accounts, in the 2015 period;
- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $57 million and $95 million, respectively, in the year ended December 31, 2015 compared to the year ended December 31, 2014;
- An increase of $32 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- Higher interest payments of $133 million.

SOURCES OF REVENUE

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

Table of Contents

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

	Years Ended December 31,		
Net Patient Revenues from:	**2015**	**2014**	**2013**
Medicare	20.4 %	22.0 %	21.9 %
Medicaid	8.7 %	9.6 %	9.2 %
Managed care	60.6 %	58.4 %	58.0 %
Indemnity, self-pay and other	10.3 %	10.0 %	10.9 %

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

	Years Ended December 31,		
Admissions from:	**2015**	**2014**	**2013**
Medicare	26.7 %	27.5 %	28.0 %
Medicaid	8.0 %	10.3 %	11.7 %
Managed care	57.5 %	54.5 %	50.0 %
Indemnity, self-pay and other	7.8 %	7.7 %	10.3 %

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services is the single largest payer of healthcare services in the United States. Approximately 126 million Americans rely on healthcare benefits through Medicare, Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and directed by CMS, an agency of the U.S. Department of Health and Human Services ("HHS"). Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

The Affordable Care Act

The ACA, which was signed into law on March 23, 2010, changes how healthcare services in the United States are covered, delivered and financed. One key provision of the ACA is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. Those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty. The penalty percentage increases through 2016, and is adjusted for inflation beginning in 2017. For individuals who are not exempt from the individual mandate, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Following legal challenges seeking to limit the availability of premium credits and subsidies only to individuals enrolled in coverage through a state-based exchange, the U.S. Supreme Court in June 2015 upheld U.S. Internal Revenue Service regulations extending such subsidies to individuals who purchase coverage through the federal government's health insurance exchange. As of December 31, 2015, we operated hospitals in two states that run their own health insurance exchanges and 13 states that rely on the federal exchange.

The "employer mandate" provision of the ACA requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those

working 30 or more hours per week. In February 2014, certain requirements of the employer mandate were partially delayed. Employers with 100 or more full time equivalent employees were required to insure at least 70% of their employees beginning in 2015 and 95% of their employees by 2016; employers with 50-99 full time equivalent employees are required to start insuring their employees in

Table of Contents

2016. We cannot predict what action the federal government might take to lift or extend the delay or the impact of any such action on insurance coverage.

Another key provision of the ACA is the expansion of Medicaid coverage. Prior to the passage of the ACA, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The ACA expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. Under the ACA, the federal government will pay 100% of the costs of Medicaid expansion in 2014, 2015 and 2016; federal funding will be reduced to 90% over the course of the four-year period from 2017 through 2020, and it will remain at 90% for 2021 and beyond. The expansion of the Medicaid program in each state requires state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. At December 31, 2015, 31 states and the District of Columbia have taken action to expand Medicaid, and one other is considering action to expand in the near future. We currently operate hospitals in six of the states (Arizona, California, Illinois, Massachusetts, Michigan and Pennsylvania) that have expanded their Medicaid programs. We cannot provide any assurances as to whether or when the other states in which we operate might choose to expand their Medicaid programs.

We anticipate that healthcare providers will continue to generally benefit over time from insurance coverage provisions of the ACA; however, the ACA also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending to offset the cost of ACA or reduce payments for uncompensated care as the number of uninsured individuals declines, including: (1) negative adjustments to the annual market basket updates for Medicare inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and (2) reductions to Medicare and Medicaid disproportionate share hospital ("DSH") payments, which began for Medicare payments in federal fiscal year ("FFY") 2014 and will begin for Medicaid payments in FFY 2018. We are unable to predict the net effect of the ACA on our future revenues and operations at this time due to uncertainty regarding the ultimate number of uninsured individuals who will obtain and retain insurance coverage, uncertainty regarding future negotiations with payers, uncertainty regarding Medicaid expansion, and gradual and, in some cases, delayed implementation. Furthermore, we are unable to predict the outcome of continuing legal challenges to certain provisions of the ACA, what action, if any, Congress might take with respect to the ACA or the actions individual states might take with respect to expanding Medicaid coverage. For a discussion of the risks and uncertainties associated with the ACA, including the future course of related legislation and regulations, see Item 1A, Risk Factors, of Part I of this report.

Table of Contents

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues from our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2015, 2014 and 2013 are set forth in the following table:

	Years Ended December 31,		
Revenue Descriptions	**2015[1]**	**2014[1]**	**2013**
Medicare severity-adjusted diagnosis-related group — operating	$ 1,744	$ 1,677	$ 1,201
Medicare severity-adjusted diagnosis-related group — capital	161	154	107
Outliers	61	69	53
Outpatient	953	896	594
Disproportionate share	337	370	250
Direct Graduate and Indirect Medical Education[2]	256	250	138
Other[3]	5	98	42
Adjustments for prior-year cost reports and related valuation allowances	62	30	32
Total Medicare net patient revenues	**$ 3,579**	**$ 3,544**	**$ 2,417**

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as TRMC, Resolute Health Hospital, Emanuel Medical Center, Hi-Desert Medical Center and our hospitals located in Tucson, Arizona.
(2) Includes Indirect Medical Education revenue earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.
(3) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

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

Acute Care Hospital Inpatient Prospective Payment System

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

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

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

hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

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

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

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC DSH Amount"). The UC DSH Amount is a hospital's share of a pool of funds that equal 75% of what otherwise would have been paid as Medicare DSH, adjusted for changes in the percentage of individuals that are uninsured. For FFY 2014, each Medicare DSH hospital's share of the UC DSH Amount pool is based on its share of insured low income days reported by all Medicare DSH hospitals. Generally, the factors used to calculate and distribute the UC DSH pool are set forth in ACA and are not subject to administrative or judicial review. The annual estimate of the size of the pool is made by the CMS Office of the Actuary and is based on the projections of total DSH payments that would have been made under the pre-ACA formula. Although the statute requires that each hospital's cost of uncompensated care as a percentage of the total uncompensated care cost of all DSH hospitals be used to allocate the pool, CMS determined that the available cost data was unreliable and is using low income days (i.e., Medicaid days) to distribute the pool. Although CMS indicated that it would provide additional information regarding the UC DSH allocation basis in the FFY 2017 IPPS Proposed Rule, we cannot predict what action, if any, CMS will take, the timing of such action, or what impact such action will have on our net revenues and cash flows.

During 2015, 71 of our acute care hospitals in continuing operations qualified for Medicare DSH payments. One of the variables used in the pre-ACA DSH formula is the number Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Original Medicare Plan patients, but also Medicare Advantage patients in the SSI ratio. The statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates ("FFY 2005 Final Rule"). We are not able to predict what action the Secretary might take with respect to the DSH calculation in this regard; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of Direct Graduate Medical Education

("DGME") and Indirect Medical Education ("IME") payments. During 2015, 30 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments.

Table of Contents

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 periodically updates the APCs and annually adjusts the rates paid for each APC.

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient prospective payment system. The IPF-PPS is based on prospectively determined per-diem rates and includes an outlier policy that authorizes additional payments for extraordinarily costly cases. At December 31, 2015, 27 of our general hospitals operated IPF units.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system. At December 31, 2015, we operated one freestanding IRF, and 20 of our general hospitals operated IRF units.

Physician Services Payment System

Medicare pays for physician and other professional services based on a list of services and their payment rates called the Medicare Physician Fee Schedule ("MPFS"). In determining payment rates for each service on the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations and other factors. The conversion factor updates payments for physician services every year according to payment updates and provisions prescribed by The Medicare Access and Children's Health Insurance Program Act ("MACRA") that was signed into law on April 16, 2015.

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.

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

Table of Contents

state-funded managed care Medicaid programs, constituted approximately 18.3%, 18.1% and 16.5% of total net patient revenues before provision for doubtful accounts of our continuing general hospitals for the years ended December 31, 2015, 2014 and 2013, respectively. We also receive DSH payments under various state Medicaid programs. For the years ended December 31, 2015, 2014 and 2013, our total Medicaid supplemental revenues attributable to DSH and other supplemental revenues, including California provider fee program and Texas 1115 waiver program revenues described on the next page, were approximately $888 million, $817 million and $428 million, respectively. The 2013 amount includes only three months of revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013. During the year ended December 31, 2015, we recorded an unfavorable adjustment of $35 million to reduce Medicaid supplemental revenues recognized over the past several years by our Valley Baptist hospitals in South Texas. This adjustment was necessary as a result of the state's recent review and update of several factors that influence payments to individual hospitals and state funding levels. Also during the year ended December 31, 2015, we recognized a $41 million favorable adjustment to increase the Medicaid supplemental revenues of our Detroit hospitals ($21 million of which related to the year ended December 31, 2014). This adjustment related to a recent update by Michigan of estimated funding levels, which increased as result of the expansion of the state's Medicaid program effective April 1, 2014.

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 Governor of California signed the Hospital Quality Assurance Fee ("HQAF") renewal bill into law in October 2013, extending California's provider fee program for three years beginning January 2014 (with a framework to renew the program for at least three additional years beyond 2016), and CMS approved the 36-month HQAF program in the three months ended December 31, 2014. As of December 31, 2015, we expect the 36-month HQAF program will result in revenues for our hospitals, net of provider fees and other expenses, of approximately $574 million in total.

Certain of our Texas hospitals began to participate in the Texas Section 1115 demonstration waiver program. The current waiver five-year term expires on September 30, 2016, is funded by intergovernmental transfer payments from local government entities, and includes two funding pools – Uncompensated Care and Delivery System Reform Payment. In 2015, we recognized $133 million of revenues from the Texas 1115 waiver programs. Separately, during the same period, we incurred $121 million of expenses related to funding indigent care services by certain of our Texas hospitals. On September 30, 2015, the State of Texas submitted a request to CMS to extend the 1115 waiver program for a period of five years. We cannot provide any assurances as to the extension of the 1115 waiver program, or the ultimate amount of revenues that our hospitals may receive from this program in 2016 or future periods.

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

Table of Contents

Medicaid-related patient revenues recognized by our continuing general hospitals from Medicaid-related programs in the states in which they are located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2015, 2014 and 2013 are set forth in the table below:

	Years Ended December 31,					
	2015[1]		2014[1]		2013	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Michigan	$ 366	$ 306	$ 337	$ 270	$ 64	$ 96
California	343	401	311	257	241	162
Texas	264	237	280	223	150	148
Florida	97	162	158	103	176	61
Illinois	88	50	80	32	33	6
Georgia	69	39	73	36	76	35
Missouri	50	14	67	9	64	6
Pennsylvania	66	206	73	194	74	200
Massachusetts	37	50	39	46	9	8
North Carolina	28	6	26	5	31	3
Alabama	37	—	12	—	13	—
South Carolina	16	33	18	34	25	26
Tennessee	6	32	7	29	6	27
Arizona	(16)	195	1	113	9	21
	$1,451	$1,731	$1,482	$1,351	$ 971	$ 799

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as TRMC, Resolute Health Hospital, Emanuel Medical Center, Hi-Desert Medical Center and our hospitals located in Tucson, Arizona.

Regulatory and Legislative Changes

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

payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government healthcare program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows. Recent regulatory and legislative updates to the Medicare and Medicaid payment systems are provided below.

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year. On July 31, 2015, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2016 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.4% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of EHR technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS is also making certain adjustments to the estimated 2.4% market basket increase that result in a net market basket update of 0.9% (before budget neutrality adjustments), including:

  - Market basket index and multifactor productivity reductions required by the ACA of 0.5% and 0.2%, respectively; and

Table of Contents

  - A documentation and coding recoupment reduction of 0.8% as required by the American Taxpayer Relief Act of 2012;

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

- A 0.85% net increase in the capital federal MS-DRG rate; and

- A decrease in the cost outlier threshold from $24,626 to $22,544.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 0.4% increase in payments for hospitals in large urban areas (populations over one million). The payment and policy changes result in an estimated 1.4% decrease in our annual IPPS payments, which yields an estimated reduction of approximately $35 million in our annual Medicare IPPS payments. Most of this decrease is due to an expected decline in Medicare UC-DSH reimbursement. Because of the uncertainty regarding factors that may influence our future IPPS payments by individual hospital, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate.

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

On October 30, 2015, CMS released the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System changes for calendar year 2016 ("Final OPPS/ASC Rule"). The Final OPPS/ASC Rule includes the following payment and policy changes:

- An estimated net decrease in the OPPS rates of 0.3% based on the projected market basket increase of 2.4% reduced by a multifactor productivity adjustment of 0.5%, an additional

0.2% adjustment required by the ACA and a 2.0% reduction to correct for inflation in OPPS payment rates;

- Changes to the two-midnight rule under CMS' short inpatient hospital stay policy, including a case-by-case exceptions policy for stays spanning fewer than two midnights, and the shifting of patient status medical reviews from Medicare Administrative Contractors to Quality Improvement Organizations; and

- A 0.3% increase in the ASC payment rates for ASCs that meet the quality reporting requirements under the ASC Quality Reporting Program.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS/ASC Rule will yield an average 0.4% decrease in OPPS payments for all facilities and an average 0.3% decrease in OPPS payments for facilities in large urban areas (populations over one million). Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS/ASC Rule on our facilities is a decrease of approximately $8 million in Medicare outpatient revenues. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative action, volumes and case mix, we cannot provide any assurances regarding our estimate of the impact of these changes.

The Medicare Access and CHIP Reauthorization Act of 2015

On April 16, 2015, the President signed the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which made numerous changes to Medicare, Medicaid, and other healthcare and related programs, as well as averted a 21% reduction to Medicare payments under the Medicare Physician Fee Schedule ("MPFS") that was scheduled to take effect on April 1, 2015. Significant provisions of the legislation include:

- Freezing MPFS payment rates at then-current levels for the period from April 1 through June 30, 2015, and then increasing the rates by 0.5% for services furnished during the last six months of 2015;

Table of Contents

- Replacing the Sustainable Growth Rate ("SGR") formula with new systems for establishing the annual updates to payment rates for physicians' services in Medicare; specifically,

  - Payments made under the MPFS will increase by 0.5% per year for services furnished during calendar years 2016 through 2019;

  - Payment rates for services on the MPFS will remain at the 2019 level through 2025, but the amounts paid to individual providers will be subject to adjustment through one of two mechanisms, depending on whether the physician chose to participate in the Merit-Based Incentive Payment System or an Alternative Payment Model ("APM") program; and

  - For 2026 and subsequent years, there will be two payment rates for services on the MPFS; for providers paid through an APM program, payment rates will be increased each year by 0.75%, while payment rates for other providers will be increased each year by 0.25%;

- Temporarily extending through 2017 the CHIP and a number of other expiring provisions, some of which increase payments to hospitals, physicians and ambulance providers;

- Delaying by one year the effective date and revising the reductions to Medicaid DSH allotments to states as required by the ACA from FFY 2017 to 2018;

- Extending through the remainder of FFY 2015 the two-midnight rule regarding certain medical patient status review activities conducted by Medicare Administrative Contractors and Recovery Audit Contractors (on August 12, 2015, CMS announced that it would extend until December 31, 2015 the moratorium on enforcement of the two-midnight policy);

- Making permanent a subsidy of Part B premiums for certain low-income Medicare beneficiaries and the availability of up to one year of additional Medicaid benefits for certain low-income families who would otherwise lose such coverage; and

- Partially offsetting the budgetary cost of these provisions—largely by reducing updates to Medicare's payment rates for services furnished by hospitals and providers of post-acute care, and by increasing premiums paid by Medicare enrollees who have relatively high income.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On October 30, 2015, CMS issued a final rule updating the MPFS for calendar year 2016 ("MPFS Final Rule"). The final rule contains various provisions to update payment rates and policies, including an update mandated by the MACRA described above, along with quality provisions for services furnished under the MPFS. The MPFS Final Rule also begins to implement other provisions under the law, which will over time replace the SGR formula, with new payment systems for physicians and other practitioners. Payment and policy changes in the MPFS Final Rule include:

- A net decrease of 0.29% in the MPFS payment rates resulting from a 0.5% update to the payment rates mandated by the MACRA, a negative 0.02% Relative Value Unit Budget Neutrality Adjustment and a 0.77% negative Target Recapture Amount required by the Protecting Access to Medicare Act of 2014 and quality provisions for services furnished under the MPFS;

- New exceptions to the physician self-referral law allowing payments to physicians to employ non-physician practitioners and allowing timeshare arrangements for the use of office space, equipment, personnel, supplies and other services;

- Additional guidance and clarification of terminology related to how financial relationships are documented;

Table of Contents

- Clarification of the calculation of the percentage of physician ownership of a hospital, which is limited under the ACA to specify that the percentage would include all doctors rather than just those who refer to the hospital; and

- Providing payment for certain advance care planning services provided by physicians and other practitioners to Medicare beneficiaries.

Comprehensive Care for Joint Replacement Final Rule

On November 16, 2015, CMS issued the Comprehensive Care for Joint Replacement ("CJR") Final Rule ("CJR Final Rule"). The CCJR Final Rule introduces a fee-for-service demonstration payment model that will hold hospitals financially accountable for the quality of care delivered to Medicare fee-for-service beneficiaries for lower extremity joint replacement ("LEJR") (i.e., hip and knee

replacement) episodes from surgery through recovery for a period of 90 days following discharge. With some limited exceptions, the five-year demonstration program is effective on April 1, 2016 and is mandatory for all IPPS hospitals located in 67 geographic areas. Beginning in 2017, participating hospitals will be eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria.

As of December 31, 2015, 20 of our acute care hospitals and four short-stay surgical hospitals operated by our USPI joint venture are located in one of the 67 geographic areas selected by CMS for the CJR demonstration program. We cannot predict what impact, if any, the CJR Final Rule will have on our inpatient volumes, net revenues or cash flows.

Bipartisan Budget Act of 2015

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

- Medicare Part B premium relief for the 30% of beneficiaries facing massive increases beginning in 2016;
- An extension through FFY 2025 of a 2% reduction (referred to as the "sequestration adjustment") to all Medicare payments, mandated by the Budget Control Act of 2011, that was originally scheduled to expire in 2021 and subsequently extended through 2024; and
- Creation of a site-neutral payment policy for services provided in off-campus outpatient departments of hospitals. This provision:
  - Creates a permanent exemption from site-neutral payment adjustments for off-campus hospital-based emergency departments;
  - Grandfathers off-campus hospital outpatient departments that billed for services under the OPPS as of the date of enactment; and
  - Provides that, beginning January 1, 2017, off-campus hospital outpatient departments that are not grandfathered or exempt will be paid under the MPFS or ASC fee schedule.

Medicare Claims Reviews

HHS estimates that approximately 12.1% of all Medicare Fee-For-Service ("FFS") claim payments in FFY 2015 were improper. CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of

Table of Contents

Medicare Trust Fund dollars. As a result, in addition to the Recovery Audit Contractor ("RAC") program, which currently performs post-payment claims reviews, CMS has recently established initiatives to prevent improper payments before a claim is processed. These initiatives include a significant increase in the number of prepayment claims reviews performed by MACs.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment claims denials are subject to administrative and judicial review.

We have established robust protocols to respond to claims reviews and payment denials. Payment recoveries resulting from MAC reviews can be appealed through administrative and judicial processes, and we intend to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

The American Recovery and Reinvestment Act of 2009

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

During the year ended December 31, 2015, we recognized approximately $72 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of 54 of our hospitals, and certain of our employed physicians and Ambulatory Care segment facilities, demonstrating meaningful use of certified EHR technology. The final Medicare EHR incentive payments are determined when the cost report that begins in the federal fiscal year during which the hospital achieved meaningful use is settled. Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

We anticipate recognizing approximately $30 million of Medicare and Medicaid EHR incentive payments in 2016. In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Eligible hospitals must continue to demonstrate meaningful use of EHR technology every year to avoid payment reductions in subsequent years. These reductions, which will be based on the market basket update, will be phased in over three years and will continue until a hospital achieves compliance. Should all of our hospitals fail to become meaningful users (or fail to continue to demonstrate meaningful use) of EHRs and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of up to $30 million in 2016 and up to $60 million in 2017 and subsequent years.

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

PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service healthcare delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate healthcare can be efficiently delivered in the most cost-

effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted healthcare providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted healthcare providers. PPO members who use contracted healthcare providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible healthcare plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient revenues during the years ended December 31, 2015, 2014 and 2013 was $10.6 billion, $9.3 billion and $6.3 billion, respectively. Approximately 62% of our managed care net patient revenues for the year ended December 31, 2015 was derived from our top ten managed care payers. National payers generated approximately 48% of our total net managed care revenues. The remainder comes from regional or local payers. At December 31, 2015 and 2014 approximately 59% and 60%, respectively, of our net accounts receivable related to continuing operations were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at December 31, 2015, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefitted from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate recently, and we believe the moderation could continue in future years. In the year ended December 31, 2015, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% 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.

Table of Contents

SELF-PAY PATIENTS

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

Self-pay accounts pose significant collectability problems. At December 31, 2015 and 2014, approximately 5% and 7%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary. Under the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), a new Consumer Financial Protection Bureau ("CFPB") was formed within the U.S. Federal Reserve to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. We believe that the CFPB regulatory and enforcement processes will have a significant impact on Conifer's operations.. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of this report.

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

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

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

sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The following table shows our estimated costs (based on selected operating expenses) of caring for self-pay patients and charity care patients, as well as revenues attributable to DSH and other supplemental revenues we recognized, in the

Table of Contents

years ended December 31, 2015, 2014 and 2013,

	Years Ended December 31,		
	2015	2014	2013
Estimated costs for:			
Self-pay patients	$ 678	$ 620	$ 545
Charity care patients	$ 191	$ 180	$ 158
DSH and other supplemental revenues	$ 888	$ 817	$ 428

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

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

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2015 and 2014:

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

Table of Contents

	Years Ended December 31,		
	2015	2014	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.5 %	0.1 %	0.4 %
Operating expenses:			
Salaries, wages and benefits	48.4 %	48.3 %	0.1 %
Supplies	15.9 %	15.8 %	0.1 %
Other operating expenses, net	24.4 %	24.8 %	(0.4)%
Electronic health record incentives	(0.4)%	(0.6)%	0.2 %
Depreciation and amortization	4.3 %	5.1 %	(0.8)%
Impairment and restructuring charges, and acquisition-related costs	1.7 %	0.9 %	0.8 %
Litigation and investigation costs	1.5 %	0.2 %	1.3 %
Gains on sales, consolidation and deconsolidation of facilities	(1.0)%	— %	(1.0)%
Operating income	**5.7 %**	**5.6 %**	**0.1 %**

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

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

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 75 hospitals and six health plans operated throughout the years ended December 31, 2015 and 2014. The results of TRMC, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, Emanuel Medical Center, which we acquired on August 1, 2014, Hi-Desert Medical Center, which we began operating on July 15, 2015, our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, SLUH, which we sold on August 31, 2015, our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and DMC Surgery Hospital, which we closed in October 2015, are excluded. Certain previously reported information has been reclassified to conform to the current-year presentation, primarily related to the sale of SLUH and our contribution of freestanding ambulatory surgery and imaging center assets to the

Table of Contents

USPI joint venture. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

	Same Hospital Continuing Operations		
	Years Ended December 31,		
Selected Operating Expenses	2015	2014	Increase (Decrease)
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits	$ 7,438	$ 7,005	6.2 %
Supplies	2,590	2,459	5.3 %
Other operating expenses	3,779	3,569	5.9 %
Total	$ 13,807	$ 13,033	5.9 %
Salaries, wages and benefits per adjusted patient admission[1]	$ 5,579	$ 5,433	2.7 %
Supplies per adjusted patient admission[1]	1,943	1,889	2.9 %
Other operating expenses per adjusted patient admission[1]	2,856	2,774	3.0 %
Total per adjusted patient admission	$ 10,378	$ 10,096	2.8 %
Ambulatory Care			
Salaries, wages and benefits	$ 301	$ 87	246.0 %
Supplies	188	61	208.2 %
Other operating expenses	196	74	164.9 %
Total	$ 685	$ 222	208.6 %
Conifer			
Salaries, wages and benefits	$ 852	$ 727	17.2 %
Other operating expenses	296	263	12.5 %
Total	$ 1,148	$ 990	16.0 %
Rent/lease expense[2]			
Hospital Operations and other	$ 214	$ 191	12.0 %
Conifer	16	21	(23.8)%
Ambulatory Care	41	22	86.4 %
Total	$ 271	$ 234	15.8 %

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

(2) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

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

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of our same 75 hospitals and six health plans operated throughout the years ended December 31, 2015 and 2014. The results of TRMC, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, Emanuel Medical Center, which we acquired on August 1, 2014, Hi-Desert Medical Center, which we began operating on July 15, 2015, our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, SLUH, which we sold on August 31, 2015, our joint venture

with Baptist Health System, Inc., which we formed on October 2, 2015, and DMC Surgery Hospital, which we closed in October 2015, are excluded. Certain previously reported information has been reclassified to conform to the current-year presentation, primarily related to the sale of SLUH and our contribution of freestanding ambulatory surgery and imaging center assets to the USPI joint venture. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

	Same-Hospital Continuing Operations		
	Years Ended December 31,		
Admissions, Patient Days and Surgeries	**2015**	**2014**	**Increase (Decrease)**
Total admissions	774,480	765,951	1.1 %
Adjusted patient admissions[1]	1,333,227	1,301,936	2.4 %
Paying admissions (excludes charity and uninsured)	733,155	722,455	1.5 %
Charity and uninsured admissions	41,325	43,496	(5.0)%
Admissions through emergency department	489,401	479,805	2.0 %
Paying admissions as a percentage of total admissions	94.7 %	94.3 %	0.4 % [2]
Charity and uninsured admissions as a percentage of total admissions	5.3 %	5.7 %	(0.4)% [2]
Emergency department admissions as a percentage of total admissions	63.2 %	62.6 %	0.6 % [2]
Surgeries — inpatient	211,063	209,385	0.8 %
Surgeries — outpatient	276,890	273,248	1.3 %
Total surgeries	487,953	482,633	1.1 %
Patient days — total	3,573,155	3,566,694	0.2 %
Adjusted patient days[1]	6,083,749	5,993,861	1.5 %
Average length of stay (days)	4.61	4.66	(1.1)%
Number of hospitals (at end of period)	75	75	— [2]
Licensed beds (at end of period)	19,882	19,984	(0.5)%
Average licensed beds	19,969	19,905	0.3 %
Utilization of licensed beds[3]	49.0 %	49.1 %	(0.1)% [2]

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

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

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

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

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

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

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $374 million and $381 million for the years ended December 31, 2015 and 2014, respectively. Net outpatient revenues include self-pay revenues of $618 million and $644 million for the years ended December 31, 2015 and 2014, respectively.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2015	2014	Increase (Decrease)
Net inpatient revenue per admission	$ 13,014	$ 12,553	3.7 %
Net inpatient revenue per patient day	$ 2,821	$ 2,696	4.6 %
Net outpatient revenue per visit	$ 719	$ 703	2.3 %
Net patient revenue per adjusted patient admission[1]	$ 11,783	$ 11,434	3.1 %
Net patient revenue per adjusted patient day[1]	$ 2,582	$ 2,484	3.9 %

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

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2015	2014	Increase (Decrease)
Provision for doubtful accounts	$ 1,375	$ 1,250	10.0 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	8.2 %	8.0 %	0.2 %[1]

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

REVENUES

Same-hospital net operating revenues increased $781 million, or 5.4%, during the year ended December 31, 2015 compared to the year ended December 31, 2014. The increase in same-hospital net operating revenues in the 2015 period is primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts, incremental net revenues from the California provider fee program of $15 million and an increase in our other operations revenues. For the years ended December 31, 2015 and 2014, our net operating revenues attributable to Medicaid DSH and other supplemental revenues were approximately $840 million and $775 million, respectively. Same-hospital net inpatient revenues increased $464 million, or 4.8%, and same-hospital admissions increased 1.1% in the 2015 period compared to the 2014 period. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy. Same-hospital net inpatient revenue per admission increased 3.7%, 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, 2015. Same-hospital net outpatient revenues increased $359 million, or 6.8%, and same-hospital outpatient visits increased 4.5% in the year ended December 31, 2015 compared to the year ended December 31, 2014. Growth in outpatient revenues and volumes was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program.

Table of Contents

Same-hospital net outpatient revenue per visit increased 2.3% primarily due to the improved terms of our managed care contracts.

PROVISION FOR DOUBTFUL ACCOUNTS

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.2% and 8.0% for the years ended December 31, 2015 and 2014, respectively. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2015 and December 31, 2014:

	December 31, 2015			December 31, 2014		
	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	$ 360	$ —	$ 360	$ 323	$ —	$ 323
Medicaid	70	—	70	153	—	153
Net cost report settlements payable and valuation allowances	(42)	—	(42)	(51)	—	(51)
Managed care	1,715	126	1,589	1,528	99	1,429
Self-pay uninsured	509	436	73	578	482	96
Self-pay balance after insurance	208	142	66	210	133	77
Estimated future recoveries from accounts assigned to our Conifer subsidiary	144	—	144	125	—	125
Other payers	442	166	276	337	125	212
Total Hospital Operations and other	3,406	870	2,536	3,203	839	2,364
Ambulatory Care	182	17	165	49	12	37
Total discontinued operations	3	—	3	4	1	3
	$ 3,591	$ 887	$ 2,704	$ 3,256	$ 852	$2,404

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2015, our collection rate on self-pay accounts was approximately 29.7%. Our self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2015, 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 $10 million.

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated collection rate from managed care payers was approximately 98.0% at December 31, 2015.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) accounts receivable days outstanding ("AR Days"), and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from Hospital Operations and other segment of $2.578 billion and $2.415 billion at

Table of Contents

December 31, 2015 and 2014, respectively, excluding cost report settlements payable and valuation allowances of $42 million and $51 million at December 31, 2015 and 2014, respectively:

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

	December 31, 2014				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	81 %	44 %	66 %	29 %	61 %
61-120 days	9 %	22 %	16 %	19 %	16 %
121-180 days	4 %	12 %	7 %	11 %	7 %
Over 180 days	6 %	22 %	11 %	41 %	16 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

Our AR Days from continuing operations were 49.5 days at both December 31, 2015 and December 31, 2014, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2015, we had a cumulative total of patient account assignments to our Conifer subsidiary of approximately $2.7 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medicaid Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. At the present time, our newly acquired facilities are beginning to implement this program. Based on recent trends, approximately 94% 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, 2015 and December 31, 2014 by aging category:

	December 31, 2015	December 31, 2014
0-60 days	$ 86	$ 85
61-120 days	14	20
121-180 days	7	10
Over 180 days	18	16
Total	**$ 125**	**$ 131**

JAN 9 2017 PM 3:51

Table of Contents

SALARIES, WAGES AND BENEFITS

Same-hospital salaries, wages and benefits per adjusted patient admission increased by 2.7% in the year ended December 31, 2015 compared to the same period in 2014. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, and increased employee health benefits and incentive compensation costs. Salaries, wages and benefits expense for the year ended December 31, 2015 and 2014 included stock-based compensation expense of $77 million and $51 million, respectively.

At December 31, 2015, approximately 20% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 37 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating first contracts at two of our hospitals where employees selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2016.

SUPPLIES

Supplies expense per adjusted patient admission for our Hospital Operations and other segment increased by 2.9% in the year ended December 31, 2015 compared to the same period in 2014. The increase in supplies expense per adjusted patient admission was primarily attributable to higher costs for pharmaceuticals and cardiology supplies, as well as volume growth in our supply-intensive surgical services, partially offset by lower implant costs.

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

OTHER OPERATING EXPENSES, NET

Same-hospital other operating expenses per adjusted patient admission increased by 3.0% in the year ended December 31, 2015 compared to the same period in 2014. Other operating expenses on a per adjusted admission basis were impacted by:

- higher same-hospital malpractice expense of $46 million;
- increased information systems maintenance contract costs of $45 million;
- additional costs related to a greater number of employed and contracted physicians for hospitals we operated throughout both periods of $56 million; and
- increased costs associated with funding indigent care services by the Texas hospitals we operated throughout both periods of $9 million, which costs were substantially offset by additional net patient revenues.

Same-hospital malpractice expense was higher in the year ended December 31, 2015 compared to the year ended December 31, 2014 due to incremental patient volumes and unfavorable adjustments to settle various cases to mitigate the risk of protracted litigation, partially offset by a favorable adjustment in the 2015 period of approximately $3 million due to a 12 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of approximately $7 million as a result of a 48 basis point decrease in the interest rate in the 2014 period.

Table of Contents

Ambulatory Care Segment

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI into our new USPI joint venture, and we acquired Aspen, which operates nine private short-stay surgical hospitals and clinics in the United Kingdom, thereby forming our new Ambulatory Care separate reportable business segment. The results of our USPI joint venture and Aspen are included in the financial and statistical information provided only for the period from acquisition to December 31, 2015. Information that is reported on a same-facility basis relates to the freestanding ambulatory surgery and diagnostic imaging centers that we operated throughout the year ended December 31, 2015 and 2014 and were contributed to the USPI joint venture.

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

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

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. In many of the facilities operated by our Ambulatory Care segment (139 of 333 at December 31, 2015), 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. We control 194 of the facilities we operate and 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 us is classified within "net income attributable to noncontrolling interests."

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

- equity in earnings of unconsolidated affiliates—our share of the net income of each facility, which is based on the facility's net income and the percentage of the facility's outstanding equity interests owned by us; and
- management and administrative services revenues, which is included in our net operating revenues—income we earn in exchange for managing the day-to-day operations of each

facility, usually quantified as a percentage of each facility's net revenues less bad debt expense.

Our Ambulatory Care operating income is driven by the performance of all facilities we operate and by our ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 58% of our facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

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

	Years Ended December 31,		
Ambulatory Care Results of Operations	**2015**	**2014**	**Increase (Decrease)**

Table of Contents

Net operating revenues	$ 959	$ 320	199.7 %
Equity in earnings of unconsolidated affiliates	83	—	—
Operating expenses, excluding depreciation and amortization	689	222	210.4 %
Gains on sales, consolidation and deconsolidation of facilities	(32)	—	—
Depreciation and amortization	46	14	228.6 %
Operating income	**$ 339**	**$ 84**	303.6 %

Our Ambulatory Care net operating revenues increased by $639 million, or 199.7%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. The growth in revenues was driven by increases from acquisitions of $603 million, and increases from our same-facility operations of $36 million, for the year ended December 31, 2015 compared to the year ended December 31, 2014.

Salaries, wages and benefits expense increased by $214 million, or 246.0%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. These increases were driven by increases in salaries, wages and benefits expense from acquisitions of $208 million, and increases in our same-facility salaries, wages and benefits expense of $6 million, for the year ended December 31, 2015 compared by the year ended December 31, 2014.

Supplies expense increased by $127 million, or 208.2%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. These increases were driven by increases in supplies expense from acquisitions of $117 million, and increases in our same-facility supplies expense of $10 million, for the year ended December 31, 2015 compared to the year ended December 31, 2014.

Other operating expenses increased by $120 million 157.9%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. These increases were driven by increases in other operating expenses from acquisitions of $113 million, and increases in our same-facility supplies expense of $7 million, for the year ended December 31, 2015 compared to the year ended December 31, 2014.

Facility Growth

The following table summarizes the changes in our same-facility revenue year-over-year on a systemwide basis, which includes both consolidated and unconsolidated (equity method) facilities. While we do not record the revenues of our 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, 2015
Net revenue	11.7 %
Cases	7.9 %
Net revenue per case	3.6 %

Table of Contents

Joint Ventures with Health System Partners

During the three months ended June 30, 2015, we established our new Ambulatory Care segment as a result of our joint venture with USPI and our purchase of Aspen. USPI's business model is to jointly own its facilities with local physicians and not-for-profit health systems. Accordingly, as of December 31, 2015, the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities with Health System Partners	Year Ended December 31, 2015
Facilities:	
With a health system partner	181
Without a health system partner	152
Total facilities operated	333
Change from December 31, 2014	
Acquired through USPI joint venture and Aspen acquisition	227
Other acquisitions	47
Dispositions/Mergers	(3)
Total increase in number of facilities operated	271

Conifer Segment

Our Conifer subsidiary generated net operating revenues of $1.4 billion and $1.2 billion during the years ended December 31, 2015 and 2014, respectively, a portion of which was eliminated in consolidation as described in Note 21 to the Consolidated Financial Statements. The increase in the revenue from third-party customers, which is not eliminated in consolidation, is primarily due to new clients, service growth and Conifer's acquisition of SPi Healthcare in the fourth quarter of 2014.

Salaries, wages and benefits expense for Conifer increased $125 million, or 17.2%, in the year ended December 31, 2015 compared to the year ended December 31, 2014 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to Conifer's acquisition of SPi Healthcare and expanded services to CHI.

Other operating expenses for Conifer increased $33 million, or 12.5%, in the year ended December 31, 2015 compared to the year ended December 31, 2014 due to the growth in Conifer's business primarily attributable to Conifer's acquisition of SPi Healthcare and expanded services to CHI.

Conifer continues to implement revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collection at point-of-service, and financial counseling. These initiatives are intended to reduce denials, improve service levels to patients and increase the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our

accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

Consolidated

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $318 million, including $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 4. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets,

Table of Contents

to their estimated fair values at two of our hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, these hospitals are at risk of future impairments, particularly if we spend significant amounts of capital at the hospitals without generating a corresponding increase in the hospitals' fair value or if the fair value of the hospitals' real estate or equipment declines. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million related to investments. We also recorded $25 million of employee severance costs, $6 million of restructuring costs, $19 million of contract and lease termination fees, and $100 million in acquisition-related costs, which include $55 million of transaction costs and $45 million of acquisition integration costs.

During the year ended December 31, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $153 million. This amount included a $20 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the

fair value of the hospital's real estate or equipment declines. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $23 million as of December 31, 2014 after recording the impairment charge. We also recorded $16 million of employee severance costs, $19 million of contract and lease termination fees, $3 million of restructuring costs, and $95 million in acquisition-related costs, which include $16 million of transaction costs and $79 million of acquisition integration charges.

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.

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the years ended December 31, 2015 and 2014 were $291 million and $25 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews described in Note 15 to our Consolidated Financial Statements.

Table of Contents

GAINS ON SALES, CONSOLIDATION AND DECONSOLIDATION OF FACILITIES

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

INTEREST EXPENSE

Interest expense for the year ended December 31, 2015 was $912 million compared to $754 million for the year ended December 31, 2014, primarily due to increased borrowings relating to our recent acquisitions and our $254 million payment to acquire the remaining 49% noncontrolling interest of our Valley Baptist Health System in South Texas.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9¼% senior notes due 2015 that we redeemed in the period, as well as the write-off of associated unamortized note discounts and issuance costs. During the year ended December 31, 2015, we recorded a loss of approximately $1 million.

INCOME TAX EXPENSE

During the year ended December 31, 2015, we recorded income tax expense of $68 million compared to $49 million during the year ended December 31, 2014.

NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS

Net income attributable to noncontrolling interests was $218 million for the year ended December 31, 2015 compared to $64 million for the year ended December 31, 2014. Net income attributable to noncontrolling interests for the year ended December 31, 2015 was comprised of $31 million related to our Hospital Operations and other segment, $138 million related to our Ambulatory

Care segment and $49 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $50 million was related to the Welsh, Carson, Anderson & Stowe minority interest in our USPI joint venture. The portion related to our Conifer segment is due to CHI's ownership interest in Conifer's revenue cycle subsidiary, Conifer Health Solutions, LLC.

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. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure that we use in our analysis of the performance of our business, which we define as net income (loss) attributable to our common shareholders before: (1) the cumulative effect of changes in accounting principle, net of tax; (2) net loss (income) attributable to noncontrolling interests; (3) preferred stock dividends; (4) income (loss) from discontinued operations, net of tax; (5) income tax benefit (expense); (6) investment earnings (loss); (7) gain (loss) from early extinguishment of debt; (8) net gain (loss) on sales of investments; (9) interest expense; (10) litigation and investigation benefit (costs), net of insurance recoveries; (11) hurricane insurance recoveries, net of costs; (12) net gains (losses) on sales, consolidation and deconsolidation of facilities; (13) impairment and restructuring charges and acquisition-related costs; and (14) depreciation and

Table of Contents

amortization. As is the case with all non-GAAP measures, investors should consider the limitations associated with this metric, including the potential lack of comparability of this measure from one company to another, and should recognize that Adjusted EBITDA does not provide a complete measure of our operating performance because it excludes many items that are included in our financial statements. Accordingly, investors are encouraged to use GAAP measures when evaluating our financial performance.

The following table shows the reconciliation of Adjusted EBITDA to net income attributable to our common shareholders (the most comparable GAAP term) for the years ended December 31, 2015 and 2014:

	Years Ended December 31,	
	2015	2014
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (140)	$ 12
Less: Net income attributable to noncontrolling interests	(218)	(64)
Net loss from discontinued operations, net of tax	2	(22)
Income from continuing operations	76	98
Income tax expense	(68)	(49)
Investment earnings	1	—
Loss from early extinguishment of debt	(1)	(24)
Interest expense	(912)	(754)
Operating income	1,056	925
Litigation and investigation costs	(291)	(25)
Gains on sales, consolidation and deconsolidation of facilities	186	—
Impairment and restructuring charges, and acquisition-related costs	(318)	(153)
Depreciation and amortization	(797)	(849)
Adjusted EBITDA	$ 2,276	$ 1,952

Net operating revenues	**$18,634**	**$16,603**
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	**12.2 %**	**11.8 %**

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

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2014 and 2013:

	Years Ended December 31,		
	2014	2013	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 15,518	$ 10,655	$ 4,863
Other operations	2,390	1,404	986
Net operating revenues before provision for doubtful accounts	17,908	12,059	5,849
Less provision for doubtful accounts	1,305	972	333
Net operating revenues	**16,603**	**11,087**	**5,516**
Equity in earnings of unconsolidated affiliates	**12**	**15**	(3)
Operating expenses:			
Salaries, wages and benefits	8,023	5,371	2,652
Supplies	2,630	1,784	846
Other operating expenses, net	4,114	2,701	1,413
Electronic health record incentives	(104)	(96)	(8)
Depreciation and amortization	849	545	304
Impairment and restructuring charges, and acquisition-related costs	153	103	50
Litigation and investigation costs	25	31	(6)
Operating income	**$ 925**	**$ 663**	**$ 262**

Table of Contents

	Years Ended December 31,		
	2014	2013	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.1 %	0.1 %	— %
Operating expenses:			
Salaries, wages and benefits	48.3 %	48.4 %	(0.1)%
Supplies	15.8 %	16.1 %	(0.3)%
Other operating expenses, net	24.8 %	24.4 %	0.4 %
Electronic health record incentives	(0.6)%	(0.9)%	0.3 %
Depreciation and amortization	5.1 %	4.9 %	0.2 %
Impairment and restructuring charges, and acquisition-related costs	0.9 %	0.9 %	— %
Litigation and investigation costs	0.2 %	0.3 %	(0.1)%
Operating income	**5.6 %**	**6.0 %**	**(0.4)%**

Net operating revenues of our general hospitals include inpatient and outpatient revenues, as well as nonpatient revenues (rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other

operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) services provided by our Conifer subsidiary to third parties and (4) our health plans. Revenues from our general hospitals represented approximately 87% and 88% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2014 and 2013, respectively.

Net operating revenues from our other operations were $2.390 billion and $1.404 billion in the years ended December 31, 2014 and 2013, respectively. The increase in net operating revenues from other operations during 2014 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our health plans acquired from Vanguard and additional physician practices. Equity earnings for unconsolidated affiliates included in our net operating revenues from other operations were $12 million and $15 million for the years ended December 31, 2014 and 2013, respectively.

Selected Operating Statistics for All Continuing Operations Hospitals—The tables below show certain selected operating statistics for our continuing operations on a total hospital basis, which includes the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, TRMC, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014 (in the case of Vanguard, TRMC Emanuel Medical Center, only for the period of time from acquisition to December 31, 2014) and the outpatient facilities now part of our Ambulatory Care segment beginning in 2015. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase in the scale of our operations as a result of these investments.

Table of Contents

	Years Ended December 31,		
Admissions, Patient Days and Surgeries	2014	2013	Increase (Decrease)
Hospital Operations and other			
Total admissions	791,165	558,726	41.6 %
Adjusted patient admissions[1]	1,343,511	906,472	48.2 %
Paying admissions (excludes charity and uninsured)	745,486	518,293	43.8 %
Charity and uninsured admissions	45,679	40,433	13.0 %
Admissions through emergency department	495,195	347,920	42.3 %
Paying admissions as a percentage of total admissions	94.2 %	92.8 %	1.4 % [2]
Charity and uninsured admissions as a percentage of total admissions	5.8 %	7.2 %	(1.4)% [2]
Emergency department admissions as a percentage of total admissions	62.6 %	62.3 %	0.3 % [2]
Surgeries — inpatient	215,660	155,634	38.6 %
Surgeries — outpatient	280,320	198,033	41.6 %
Total surgeries	495,980	353,667	40.2 %
Patient days — total	3,695,288	2,621,245	41.0 %
Adjusted patient days[1]	6,203,383	4,210,191	47.3 %
Average length of stay (days)	4.67	4.69	(0.4)%
Number of hospitals (at end of period)	80	77	3
Licensed beds (at end of period)	20,814	20,293	2.6 %
Average licensed beds	20,531	14,963	37.2 %
Utilization of licensed beds[3]	49.3 %	48.0 %	1.3 % [2]
Ambulatory Care			
Total Cases	561,110	348,227	61.1 %

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the 2014 and 2013 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

	Years Ended December 31,		
Outpatient Visits	2014	2013	Increase (Decrease)
Hospital Operations and other			
Total visits	7,720,886	4,767,626	61.9 %
Paying visits (excludes charity and uninsured)	7,059,962	4,255,554	65.9 %
Charity and uninsured visits	660,924	512,072	29.1 %
Emergency department visits	2,824,526	1,865,239	51.4 %
Surgery visits	280,320	198,033	41.6 %
Paying visits as a percentage of total visits	91.4 %	89.3 %	2.1 % [1]
Charity and uninsured visits as a percentage of total visits	8.6 %	10.7 %	(2.1)% [1]

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

Table of Contents

	Years Ended December 31,		
Revenues	2014	2013	Increase (Decrease)
Hospital Operations and other			
Net operating revenues	$ 15,090	$ 9,963	51.5 %
Revenues from charity and the uninsured	$ 1,061	$ 779	36.2 %
Net inpatient revenues[1]	$ 10,015	$ 6,952	44.1 %
Net outpatient revenues[1]	$ 5,448	$ 3,640	49.7 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $393 million and $324 million for the years ended December 31, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $668 million and $455 million for the years ended December 31, 2014 and 2013, respectively.

	Years Ended December 31,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)
Hospital Operations and other			
Net inpatient revenue per admission	$ 12,659	$ 12,443	1.7 %
Net inpatient revenue per patient day	$ 2,710	$ 2,652	2.2 %
Net outpatient revenue per visit	$ 706	$ 763	(7.5)%
Net patient revenue per adjusted patient admission[1]	$ 11,510	$ 11,685	(1.5)%
Net patient revenue per adjusted patient day[1]	$ 2,493	$ 2,516	(0.9)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

	Years Ended December 31,
	Increase

Provision for Doubtful Accounts	2014	2013	(Decrease)
Hospital Operations and other			
Provision for doubtful accounts	$ 1,300	$ 967	34.4 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.9 %	8.8 %	% (0.9)[1]

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

Table of Contents

Selected Operating Expenses	Years Ended December 31, 2014	2013	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 7,209	$ 4,740	52.1 %
Supplies	2,569	1,746	47.1 %
Other operating expenses	3,777	2,442	54.7 %
Total	$ 13,555	$ 8,928	51.8 %
Ambulatory Care			
Salaries, wages and benefits	$ 87	$ 55	58.2 %
Supplies	61	38	60.5 %
Other operating expenses	74	48	54.2 %
Total	$ 222	$ 141	57.4 %
Conifer			
Salaries, wages and benefits	$ 727	$ 576	26.2 %
Other operating expenses	263	211	24.6 %
Total	$ 990	$ 787	25.8 %
Total			
Salaries, wages and benefits	$ 8,023	$ 5,371	49.4 %
Supplies	2,630	1,784	47.4 %
Other operating expenses	4,114	2,701	52.3 %
Total	$ 14,767	$ 9,856	49.8 %
Rent/lease expense[1]			
Hospital Operations and other	$ 199	$ 157	26.8 %
Conifer	21	14	50.0 %
Ambulatory Care	22	15	46.7 %
Total	$ 242	$ 186	30.1 %
Hospital Operations and other[2]			
Salaries, wages and benefits per adjusted patient day	$ 1,173	$ 1,130	3.8 %
Supplies per adjusted patient day	414	415	(0.2)%
Other operating expenses per adjusted patient day	616	583	5.7 %
Total per adjusted patient day	$ 2,203	$ 2,128	3.5 %
Salaries, wages and benefits per adjusted patient admission	$ 5,417	$ 5,249	3.2 %
Supplies per adjusted patient admission	1,912	1,926	(0.7)%
Other operating expenses per adjusted patient admission	2,843	2,707	5.0 %
Total per adjusted patient admission	$ 10,172	$ 9,882	2.9 %

(1) Included in other operating expenses.
(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to our health plans and our provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals.

REVENUES

During the year ended December 31, 2014, our net operating revenues increased $5.516 billion, or 49.8%, compared to the year ended December 31, 2013. Hospital acquisitions contributed approximately $4.849 billion to the increase in our net operating revenues, while hospitals we operated throughout both periods contributed $667 million, or additional revenues of 7.8%. The increase in total hospital net operating revenues is primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts, $50 million of incremental net revenues from the California provider fee program ($165 million in 2014 compared to $115 million in 2013) and an increase in our other operations revenues. For the years ended December 31, 2014 and 2013, our net operating revenues attributable to DSH payments and other state-funded subsidy payments were approximately $817 million and $428 million, respectively.

Table of Contents

During the year ended December 31, 2014, our net inpatient revenues increased $3.063 billion, or 44.1%, compared to the same period in 2013. Net inpatient revenues from hospital acquisitions contributed approximately $2.651 billion to the increase in our net inpatient revenues, while hospitals we operated throughout both periods contributed approximately $412 million, or 6.8% more revenues. Our total admissions increased 41.6% during the year ended December 31, 2014 compared to the year ended December 31, 2013 primarily due to our hospital acquisitions in 2014 and 2013 and organic growth. Admissions at hospitals we operated at the beginning of 2013 increased 3.0% in 2014 compared to 2013. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy. We believe our inpatient volume levels continue to be constrained by an increase in patients with high-deductible health insurance plans and industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than an inpatient setting. Net inpatient revenue per admission increased 1.7% for Hospital Operations and other segment and 3.7% for hospitals we operated throughout 2014 and 2013, primarily due to the improved terms of our managed care contracts and incremental California provider fee program net revenues of our California hospitals operated at the beginning of 2013, which revenues were $150 million in 2014 compared to $115 million in 2013.

During the year ended December 31, 2014, our net outpatient revenues increased $1.808 billion, or 49.7%, and our total outpatient visits increased 61.9% compared to the same period in 2013. The growth in our outpatient revenues and volumes was related to both acquisitions and organic growth. Net outpatient revenues from acquisitions contributed approximately $1.571 billion to the increase in our net outpatient revenues, while facilities we operated throughout both periods contributed approximately $237 million, or 7.5% more revenues. The increase in total outpatient visits was primarily due to our acquisitions in 2014 and 2013. Outpatient visits associated with facilities we operated at the beginning of 2013 increased 5.2% in 2014 compared to 2013. Growth in outpatient revenues for facilities we operated throughout both periods was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program. Net outpatient revenue per visit decreased 7.5% for Hospital Operations and other segment primarily due to the lower level of patient acuity at our recently opened or acquired facilities; however, net outpatient revenue per visit for facilities we operated throughout 2014 and 2013 increased 2.1%, primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $1.193 billion and $919 million during the years ended December 31, 2014 and 2013, respectively, a portion of which was eliminated in consolidation as described in Note 21 to the Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients and expanded service offerings.

PROVISION FOR DOUBTFUL ACCOUNTS

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

Table of Contents

below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2014 and December 31, 2013:

	December 31, 2014			December 31, 2013		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 323	$ —	$ 323	$ 301	$ —	$ 301
Medicaid	153	—	153	133	—	133
Net cost report settlements payable and valuation allowances	(51)	—	(51)	(75)	—	(75)
Managed care	1,528	99	1,429	1,179	69	1,110
Self-pay uninsured	578	482	96	344	290	54
Self-pay balance after insurance	210	133	77	224	141	83
Estimated future recoveries from accounts assigned to our Conifer subsidiary	125	—	125	92	—	92
Other payers	337	125	212	233	78	155
Total Hospital Operations and other	3,203	839	2,364	2,431	578	1,853
Ambulatory Care	49	12	37	45	11	34
Total discontinued operations	4	1	3	3	—	3
	$ 3,256	$ 852	$2,404	$ 2,479	$ 589	$1,890

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

The increase in the allowance for doubtful accounts as a percentage of patient accounts receivable related to the accounts receivable acquired from Vanguard as of October 1, 2013. Under the purchase price allocation rules, allowance for doubtful accounts as of the acquisition date are offset against the gross receivables. As of the acquisition date, the acquirer begins to disclose the net receivable amount with no disclosure of the former allowance for doubtful accounts amount. Accounts receivable generated after the acquisition are disclosed before the allowance for doubtful accounts and the associated allowance for doubtful accounts is also disclosed to arrive at net accounts receivable. The increase also related to the 120 basis point decrease in our self-pay collection rate for the 49 hospitals we

operated throughout the years ended December 31, 2014 and 2013, well as higher patient co-pays and deductibles, partially offset by a decline in uninsured revenues due to the expansion of insurance coverage under the Affordable Care Act.

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2014, our collection rate on self-pay accounts for hospitals we operated throughout 2014 and 2013 was approximately 27.5%. Our recent self-pay collection rates for hospitals we operated throughout all periods were as follows: 28.8% at March 31, 2013; 28.7% at June 30, 2013; 28.8% at September 30, 2013; 28.7% at December 31, 2013; 28.1% at March 31, 2014; 27.8% at June 30, 2014; and 27.5% at September 30, 2014. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2014, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $10 million.

Table of Contents

Our estimated collection rate from managed care payers for hospitals we operated through 2014 and 2013 was approximately 98.3% at both December 31, 2014 and December 31, 2013.

The following tables present the approximate aging by payer of our net accounts receivable from Hospital Operations and other segment of $2.415 billion and $1.928 billion at December 31, 2014 and 2013, respectively, excluding cost report settlements payable and valuation allowances of $51 million and $75 million at December 31, 2014 and 2013, respectively:

	December 31, 2014				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	81 %	44 %	66 %	29 %	61 %
61-120 days	9 %	22 %	16 %	19 %	16 %
121-180 days	4 %	12 %	7 %	11 %	7 %
Over 180 days	6 %	22 %	11 %	41 %	16 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

	December 31, 2013				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	76 %	58 %	73 %	32 %	65 %
61-120 days	9 %	21 %	13 %	17 %	14 %
121-180 days	4 %	9 %	5 %	7 %	6 %
Over 180 days	11 %	12 %	9 %	44 %	15 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

Our AR Days from continuing operations were 49.5 days at December 31, 2014 and 44.7 days at December 31, 2013, within our target of less than 55 days. AR days at December 31, 2014 were negatively impacted by a temporary buildup in accounts receivable of certain hospitals acquired from Vanguard due to the implementation of a new billing system that is expected to enhance efficiency. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter

divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2014, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $2.9 billion related to our continuing operations, but excluding our recently acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Table of Contents

The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2014 and December 31, 2013 by aging category:

	December 31, 2014	December 31, 2013
0-60 days	$ 85	$ 132
61-120 days	20	28
121-180 days	10	8
Over 180 days	16	18
Total	**$ 131**	**$ 186**

SALARIES, WAGES AND BENEFITS

Salaries, wages and benefits expense as a percentage of net operating revenues decreased 0.1% for the year ended December 31, 2014 compared to the year ended December 31, 2013. Salaries, wages and benefits per adjusted patient admission for our Hospital Operations and other segment increased by approximately 3.2% in the year ended December 31, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased overtime and contract labor costs, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs. Salaries, wages and benefits expense for the year ended December 31, 2014 and 2013 included stock-based compensation expense of $51 million and $37 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $151 million in the year ended December 31, 2014 compared to the year ended December 31, 2013 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer, Conifer's acquisition of SPi Healthcare and growth in Conifer's services to CHI.

SUPPLIES

Supplies expense as a percentage of net operating revenues decreased by 0.3% for the year ended December 31, 2014 compared to the year ended December 31, 2013. Supplies expense per adjusted patient admission for our Hospital Operations and other segment decreased by 0.7% in the year ended December 31, 2014 compared to the same period in 2013. The change in supplies expense per adjusted patient admission was favorably impacted by the supplies expense control measures we have in place, including rebate arrangements, partially offset by higher costs for pharmaceuticals and implants, as well as volume growth in our supply-intensive surgical services. In general, supplies expense changes are primarily attributable to changes in our patient volume levels and the mix of procedures performed.

OTHER OPERATING EXPENSES, NET

Other operating expenses as a percentage of net operating revenues was 24.8% in the year ended December 31, 2014 compared to 24.4% in the year ended December 31, 2013. Other operating expenses per adjusted patient admission for our Hospital Operations and other segment increased by 5.0% in the year ended December 31, 2014 compared to the same period in 2013. The approximately $1.335 billion, or 54.7%, increase in other operating expenses for our Hospital Operations and other segment in the year ended December 31, 2014 compared to the year ended December 31, 2013 is primarily due to:

- increases due to hospital acquisitions of $1.099 billion;
- increased costs of contracted services for hospitals we operated throughout both periods of $46 million;
- higher medical fees primarily related to a greater number of employed and contracted physicians for hospitals we operated throughout both periods of $49 million;

Table of Contents

- increased costs associated with funding indigent care services by the Texas hospitals we operated throughout both periods of $25 million, which costs were substantially offset by additional net patient revenues; and
- increased malpractice expense for hospitals we operated throughout both periods of $57 million.

Malpractice expense in the year ended December 31, 2014 included isolated unfavorable case reserve adjustments related to a small number of claims, as well as an unfavorable adjustment of approximately $7 million due to a 48 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 $17 million as a result of an 127 basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $52 million in the year ended December 31, 2014 compared to the year ended December 31, 2013 due to higher costs related to the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer, Conifer's acquisition of SPi Healthcare and growth in Conifer's services to CHI.

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $153 million. This amount included a $20 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was

lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment declines. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $23 million as of December 31, 2014 after recording the impairment charge. We also recorded $16 million of employee severance costs, $19 million of contract and lease termination fees, $3 million of restructuring costs, and $95 million in acquisition-related costs, which include $16 million of transaction costs and $79 million of acquisition integration charges.

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors contributing to the adverse financial trends at that time 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 hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. We disclosed in our Annual Report on Form 10-K for the year ended December 31, 2013 that, unless the anticipated future financial trends of this hospital improved to the extent that the estimated future undiscounted cash flows exceeded the carrying value of the long-lived assets, this hospital was at risk of future impairments, which impairments occurred in 2014 as described above, particularly if we spent significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment

Table of Contents

declined. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination fees, and $59 million in acquisition-related costs, which included both transaction costs and acquisition integration charges.

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the year ended December 31, 2014 and 2013 were $25 million and $31 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2014 was $754 million compared to $474 million for the year ended December 31, 2013, primarily due to increased borrowings relating to our acquisitions in 2014 and 2013, and $400 million of share repurchases during 2013.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9¼% senior notes due 2015 that we redeemed in the period, as well as the write-off of associated unamortized note discounts and issuance costs.

During the year ended December 31, 2013, we recorded a loss from early extinguishment of debt of $348 million consisting of $177 million related to the difference between the purchase prices and the par values of the $714 million aggregate principal amount of our 10% senior secured notes due 2018 that we purchased and called during the period, as well as the write-off of unamortized note discounts and issuance costs, and $171 million related to the difference between the purchase prices and the par values of the $925 million aggregate principal amount of our 8⅞% senior secured notes due 2019 that we purchased and called during the period, as well as the write-off of unamortized note discounts and issuance costs.

INCOME TAX EXPENSE

During the year ended December 31, 2014, we recorded income tax expense of $49 million compared to $65 million of income tax benefit during the year ended December 31, 2013, primarily related to the loss on early extinguishment of debt in 2013.

Table of Contents

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, 2015:

		Years Ended December 31,					Later
	Total	2016	2017	2018	2019	2020	Years
				(In Millions)			
Long-term debt[1]	$ 20,070	$ 865	$ 865	$ 1,906	$ 2,359	$ 4,919	$ 9,156
Capital lease obligations[1]	1,057	142	154	71	61	44	585
Long-term non-cancelable operating leases	1,213	205	175	149	122	103	459
Standby letters of credit	110	105	5	—	—	—	—
Guarantees[2]	100	72	22	6	—	—	—
Asset retirement obligations	123	—	—	—	—	—	123
Academic affiliation agreements[3]	98	31	30	28	9	—	—
Tax liabilities	34	—	—	—	—	—	34
Defined benefit plan obligations	689	45	21	21	21	22	559
Construction and capital improvements	241	81	80	80	—	—	—
Information technology contract services	1,392	294	227	230	233	237	171
Purchase orders	352	352	—	—	—	—	—
Total[4]	$ 25,479	$ 2,192	$ 1,579	$ 2,491	$ 2,805	$ 5,325	$ 11,087

(1) Includes interest through maturity date/lease termination.
(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 Put/Call Agreement, as defined in Note 16 to our Consolidated Financial Statements, have been excluded from the table. At December 31, 2015, the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were approximately $177 million and $578 million, respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were approximately $58 million and $192 million, respectively. In January 2016, subsidiaries of Welsh, Carson, Anderson & Stowe delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to the Put/Call Agreement. The estimated amount we will pay to repurchase these shares is $127 million.

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. On March 7, 2014, we entered into a new letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit originally issued under our senior secured revolving credit facility, which we transferred to the LC Facility), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by 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.

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2015:

- In June 2015, we sold $900 million aggregate principal amount of floating rate senior secured notes, which will mature on June 15, 2020 (the "Secured Notes"), and assumed $1.9 billion aggregate principal amount of $6^3/_4$% senior notes, which will mature on June 15, 2023 (the "Unsecured Notes" and, together with the Secured Notes, the "Notes"), issued by THC Escrow Corporation II. We will pay interest on the Secured Notes quarterly

Table of Contents

in arrears on March 15, June 15, September 15 and December 15 of each year, which payments commenced on September 15, 2015. The Secured Notes accrue interest at a rate per annum, reset quarterly, equal to LIBOR plus $3^1/_2$%. We will pay interest on the Unsecured Notes semi-annually in arrears on June 15 and December 15 of each year, commencing on December 15, 2015. The proceeds from the sale of the Notes were used to repay borrowings outstanding under our Interim Loan Agreement and Credit Agreement, as well as to refinance the debt of USPI and to pay the cash consideration in respect of our USPI joint venture and Aspen acquisition.

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. At December 31, 2015, 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 5.86x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including 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 assets 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 of 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 (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements. Capital expenditures were $842 million, $933 million and $691 million in the years ended December 31, 2015, 2014 and 2013, respectively. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2016 will total approximately $850 million to $900 million, including $133 million that was accrued as a liability at December 31, 2015. Our budgeted 2016 capital expenditures include approximately $5 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree.

During the year ended December 31, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets into a new joint venture. We also completed the acquisition of Aspen, a network of nine private hospitals and clinics in the United Kingdom. In addition, we began operating Hi-Desert Medical Center, which is a 59-bed acute care hospital in Joshua Tree, California, and its related healthcare facilities, including a 120-bed skilled nursing facility, an ambulatory surgery center and an imaging center, under a long-term lease agreement. Furthermore, we formed a new joint venture with Dignity Health and Ascension Health to own and operate Carondelet Health Network, which is comprised of three hospitals with over 900 licensed beds, related physician practices, ambulatory surgery, imaging and urgent care centers, and other affiliated businesses, in Tucson and Nogales, Arizona. We also formed a new joint venture with Baptist Health Systems, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership in the joint venture, and manage the network's operations. The network has more than 1,700 licensed beds, nine outpatient centers, 68 physician clinics, delivering primarily and specialty care, and more than 7,000 employees and approximately 1,500 affiliated physicians. Additionally, we acquired majority interests in nine ambulatory surgery centers (all of which are owned by our USPI joint venture) and various physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $940 million.

Interest payments, net of capitalized interest, were $859 million, $726 million and $426 million in the years ended December 31, 2015, 2014 and 2013, respectively.

Income tax payments, net of tax refunds, were approximately $7 million in the year ended December 31, 2015 compared to approximately $8 million in the year ended December 31, 2014. At December 31, 2015, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.8 billion pretax expiring in 2024 to 2034, (2) approximately $28 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $22 million expiring in 2023 to 2035, and (4) state NOL carryforwards of $3.1 billion expiring in 2015 to 2035 for which the associated deferred tax

Table of Contents

benefit, net of valuation allowance and federal tax impact, is $12 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if our "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership by more than 50 percentage points (by value) over a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs, our offering of stock, the purchase or sale of our stock by five-percent shareholders, or the issuance or exercise of rights to acquire our 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.

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, and of Vanguard's tax returns for fiscal years ending on or before June 30, 2004. 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 Vanguard's tax returns for fiscal years ended after June 30, 2004 remain subject to examination by the IRS. Vanguard's tax returns for fiscal years ended June 30, 2013 and October 1, 2013 are currently under audit by the IRS. USPI tax returns for years ended after December 31, 2011 remain subject to audit.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2015 was primarily derived from net cash provided by operating activities, cash on hand, issuance of long-term debt and borrowings under our revolving credit facility. We had approximately $356 million of cash and cash equivalents on hand at December 31, 2015 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $995 million based on our borrowing base calculation as of December 31, 2015.

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 and levels of bad debt due to shifts in payer mix and other factors.

Net cash provided by operating activities was $1.026 billion in the year ended December 31, 2015 compared to $687 million in the year ended December 31, 2014. Key positive and negative factors contributing to the change between the 2015 and 2014 periods include the following:

- Increased income from continuing operations before income taxes of $324 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, acquisition-related costs, and depreciation and amortization in the year ended December 31, 2015 compared to the year ended December 31, 2014;

- $436 million less cash used by the change in accounts receivable, net of provision of doubtful accounts, in the 2015 period;

- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $57 million and $95 million, respectively, in the year ended December 31, 2015 compared to the year ended December 31, 2014;

- An increase of $32 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and

- Higher interest payments of $133 million.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash. These initiatives may include the sale of underutilized or inefficient assets.

Table of Contents

Capital expenditures were $842 million and $933 million in the years ended December 31, 2015 and 2014, respectively.

In November 2015, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expires in December 2016. Under the program, shares may be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations. Pursuant to the share repurchase program, we paid approximately $40 million to repurchase a total of 1,242,806 shares during the period from the commencement of the program through December 31, 2015.

In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase program, we paid approximately $100 million to repurchase a total of 3,406,324 shares during the period from the commencement of the program through December 31, 2012, and we paid approximately $400 million to repurchase a total of 9,484,974 shares during the period from January 1, 2013 to December 31, 2013.

We record our investments that are available-for-sale at fair market value. As shown in Note 19 to the Consolidated Financial Statements, 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

On December 4, 2015, we entered into an amendment to our existing senior secured revolving credit facility (as amended, "Credit Agreement") in order to, among other things, extend the scheduled maturity date of the facility, reduce the rates of certain interest and fees payable under the facility and remove certain restrictions with respect to the borrowing base eligibility of certain account receivable. The Credit Agreement 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. The Credit Agreement has a scheduled maturity date of December 4, 2020. At December 31, 2015, we were in compliance with all covenants and conditions in our Credit Agreement. At December 31, 2015, we had no cash borrowings outstanding under the revolving credit facility, and we had approximately $5 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $995 million was available for borrowing under the revolving credit facility at December 31, 2015.

On March 7, 2014, we entered into a new letter of credit facility agreement that provides for the issuance of standby and documentary letters of credit (including certain letters of credit originally issued under our Credit Agreement, which we transferred to the LC Facility), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by 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. At December 31, 2015, we had approximately $105 million of standby letters of credit outstanding under the LC Facility.

In June 2015, we sold $900 million aggregate principal amount of floating rate senior secured notes, which will mature on June 15, 2020 (the "Secured Notes"), and assumed $1.9 billion aggregate principal amount of $6^3/_4$% senior notes, which will mature on June 15, 2023 (the "Unsecured Notes" and, together with the Secured Notes, the "Notes"), issued by THC Escrow Corporation II. We will pay interest on the Secured Notes quarterly in arrears on March 15, June 15, September 15 and December 15 of each year, which payments commenced on September 15, 2015. The Secured Notes accrue interest at a rate per annum, reset quarterly, equal to LIBOR plus $3^1/_2$%. We will pay interest on the Unsecured Notes semi-annually in arrears on June 15 and December 15 of each year, which payments commenced on December 15, 2015. The proceeds from the sale of the Notes were used to repay borrowings outstanding under our Interim Loan Agreement and

Table of Contents

Credit Agreement, as well as to refinance the debt of USPI and to pay the cash consideration in respect of our USPI joint venture and Aspen acquisition.

In September 2014, we sold $500 million aggregate principal amount of 5½% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 9¼% senior notes due 2015 in July 2014. The net proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement.

In October 2013, we sold $2.8 billion aggregate principal amount of 8⅛% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8⅛% senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard.

In May 2013, we sold $1.050 billion aggregate principal amount of 4⅜% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4⅜% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, which payments commenced on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately $767 million aggregate principal amount outstanding of our 8⅞% senior secured notes due 2019 in a tender offer and to call approximately $158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold $850 million aggregate principal amount of 4½% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4½% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately $645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately $69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $177 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

For additional information regarding our long-term debt, see Note 6 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 significant 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 has 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

Table of Contents

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 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 previously announced asset divestitures, future borrowings or 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 acquire. In addition, liquidity could be adversely affected by a deterioration in our results of operations, including our ability to generate cash from operations, as well as by the various risks and uncertainties discussed in this and other sections of this report, including any costs associated with a significant monetary resolution of the Clinica de la Mama qui tam action and criminal investigation described in Note 15 to our Consolidated Financial Statements.

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 substantially all of our current long-term indebtedness has fixed rates of interest.

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are volume growth, including the acquisition of outpatient businesses, physician recruitment and alignment strategies, expansion of our Conifer services businesses, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, underperforming hospitals and portfolio optimization, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management company peers because of geographic and other differences in hospital portfolios.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the years ended December 31, 2015, 2014 and 2013 include $94 million, $49 million and $392 million, respectively, of net operating revenues and $15 million, ($1) million and $72 million, respectively, of operating income (loss) generated from hospitals operated by us under operating lease arrangements (two hospitals for the year ended December 31, 2015 and 2014, one hospital for the year ended December 31, 2013). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet. One of the hospitals operated by us under an operating lease arrangement was contributed to one of our joint ventures with Baylor Scott & White Health effective January 1, 2016, as further described in Note 4 to our Consolidated Financial Statements included in this report. The remaining operating lease is currently scheduled to expire in 2016 and may be renewed through 2046. If we are unable to extend the lease or purchase the hospital, we would no longer generate revenues or expenses from the hospital.

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 $210 million of standby letters of credit outstanding and guarantees as of December 31, 2015.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 22 to our Consolidated Financial Statements included in this report 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

Table of Contents

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 provision for doubtful accounts;
- Accruals for general and professional liability risks;
- Accruals for defined benefit plans;
- Impairment of long-lived assets;
- Impairment of goodwill; and
- Accounting for income taxes.

REVENUE RECOGNITION

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, and managed care and other health plans, as well as certain uninsured patients under the Compact.

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 DSH, DGME, IME and bad debt expense, 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 recorded by us could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording 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 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.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We

Table of Contents

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 as of December 31, 2015, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our 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.

Revenues related to self-pay patients may qualify for a discount under the Compact, whereby the gross charges based on established billing rates would be reduced by an estimated discount for contractual allowance.

We believe that adequate provision has been made for any adjustments that may result from final determination of amounts earned under all the above arrangements. We know of no material claims, disputes or unsettled matters with any payers that would affect our revenues for which we have not adequately provided for in our Consolidated Financial Statements.

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws 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 provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2015, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonable likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $10 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.

Our practice is to reduce the net carrying value of self-pay accounts receivable, including accounts related to the co-pays and deductibles due from patients with insurance, to their estimated net realizable value at the time of billing. Generally, uncollected balances are assigned to Conifer between 90 to 180 days, once patient responsibility has been identified. When accounts are assigned to Conifer by the hospital, the accounts are completely written off the hospital's books through the provision for doubtful accounts, and an estimated future recovery amount is calculated and recorded as a receivable on the hospital's books at the same time. The estimated future recovery amount is adjusted based on the

Table of Contents

aging of the accounts and changes to actual recovery rates. The estimated future recovery amount for self-pay accounts is written down whereby it is fully reserved if the amount is not paid within two years after the account is assigned to Conifer. At the present time, our new acquisitions have not yet been fully integrated into our Conifer collections processes.

Managed care accounts are collected through the regional business offices of Conifer, whereby the account balances remain in the related hospital's patient accounting system and on the hospital's books, and are adjusted based on an analysis of the net realizable value as they age. Generally, managed care accounts collected by Conifer are gradually written down whereby they are fully reserved if the accounts are not paid within two years.

Changes in the collectability of aged managed care accounts receivable are ongoing and impact our provision for doubtful accounts. We continue to experience payment pressure from managed care companies concerning amounts of past billings. We aggressively pursue collection of these accounts receivable using all means at our disposal, including arbitration and litigation, but we may not be successful.

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 claims differ from expected trends. We believe it is reasonably likely for there to be a 5% increase or decrease in the number of expected claims or average cost per claim. Based on our reserves and other information as of December 31, 2015, a 5% increase in the number of expected claims would increase the estimated reserves by $50 million, and a 5% decrease in the number of expected claims would decrease the estimated reserves by $40 million. A 5% increase in the average cost per claim would increase the estimated reserves by $50 million, and a 5% decrease in the average cost per claim would decrease the estimated reserves by $43 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 2.09%, 1.97% and 2.45% at December 31, 2015, 2014 and 2013, respectively. A 100 basis point increase or decrease in the discount rate would change the estimated reserves by $22 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, 2015, 2014 and 2013:

	December 31,		
	2015	2014	2013
Case reserves	$ 219	$ 253	$ 188
Incurred but not reported and loss development reserves	584	472	575
Total undiscounted reserves	**$ 803**	**$ 725**	**$ 763**

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

Table of Contents

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 four 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 both December 31, 2015 and 2014 representing unsettled claims is approximately 98%.

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,		
	2015	2014	2013
Accrual for professional and general liability claims, beginning of the year	$ 681	$ 711	$ 356
Assumed from acquisition	29	—	373
Expense (income) related to:[1]			
Current year	151	144	102
Prior years	95	57	13

Expense (income) from discounting	(3)	7	(13)
Total incurred loss and loss expense	243	208	102
Paid claims and expenses related to:			
Current year	(3)	(3)	(3)
Prior years	(195)	(235)	(117)
Total paid claims and expenses	(198)	(238)	(120)
Accrual for professional and general liability claims, end of year	**$ 755**	**$ 681**	**$ 711**

(1) Total malpractice expense for continuing operations, including premiums for insured coverage, was $283 million, $232 million and $112 million in the years ended December 31, 2015, 2014 and 2013, respectively.

ACCRUALS FOR DEFINED BENEFIT PLANS

Our defined benefit plan obligations and related costs are calculated using actuarial concepts. The discount rate is a critical assumption in determining the elements of expense and liability measurement. We evaluate this critical assumption annually. Other assumptions include employee demographic factors such as retirement patterns, mortality, turnover and rate of compensation increase. During the year ended December 31, 2015, the Society of Actuaries issued a new mortality improvement scale (MP-2015), which we incorporated into the estimates of our defined benefit plan obligations as of December 31, 2015. During the year ended December 31, 2014, the Society of Actuaries issued new mortality tables (RP-2014) and a mortality improvement scale (MP-2014), which we incorporated into the estimates of our defined benefit plan obligations as of December 31, 2014.

The discount rate enables us to state expected future cash payments for benefits as a present value on the measurement date. The guideline for setting these rates is a high-quality long-term corporate bond rate. A lower discount rate increases the present value of benefit obligations and impacts pension expense. Our discount rates for 2015 ranged from 4.67% to 4.75% and our discount rate for 2014 ranged from 4.16% to 4.25%. The assumed discount rate for pension plans reflects the market rates for high-quality corporate bonds currently available. A 100 basis point decrease in the assumed discount rate would increase total net periodic pension expense for 2016 by approximately $3 million and would increase the projected benefit obligation at December 31, 2015 by approximately $186 million. A 100 basis point increase in the assumed discount rate would decrease net periodic pension expense for 2016 by approximately $1 million and decrease the projected benefit obligation at December 31, 2015 by approximately $153 million.

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

Table of Contents

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, 2015, we recorded $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 4. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. Material adverse trends in our estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceeds the carrying value of the long-lived assets, these hospitals are at risk of future impairments. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million related to investments. We also had four hospitals whose estimated future undiscounted cash flows did not exceed the carrying value of long-lived assets. However, in each case, the fair value of those assets, based on independent appraisals, established market values of comparable assets or internal estimates exceeded the carrying value, so no impairment was recorded. Future adverse trends that result in necessary changes in the assumptions underlying these estimates of future undiscounted cash flows could result in the hospitals' estimated cash flows being less than the carrying value of the assets, which would require a fair value assessment of the long-lived assets and, if the fair value amount is less than the carrying value of the assets, impairment charges would occur and could be material.

Table of Contents

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.

Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI. As of December 31, 2015, our continuing operations consisted of three reportable segments, our Hospital Operations and other, Ambulatory Care and Conifer. During the three months ended June 30, 2015, within our Hospital Operations and other segment, we combined our Central region with our Resolute Health, San Antonio and South Texas markets to create our new Texas region, and we moved our hospitals and other operations in Tennessee from our Texas region to our Southern region. Our Hospital Operations and other segment is currently structured as follows:

- Our Texas region included all of our hospitals and other operations in Missouri, New Mexico and Texas;
- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region included all of our hospitals and other operations in Alabama, Georgia, South Carolina and Tennessee;
- Our Western region included all of our hospitals and other operations in Arizona and California; and
- Our Detroit market included all of our hospitals and other operations in the Detroit, Michigan area.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

The allocated goodwill balance related to our Hospital Operations and other segment totals approximately $3.122 billion, of which the Texas Region has the largest balance at $1.742 billion. In our latest impairment analysis as of December 31, 2015, the estimated fair value of the Texas Region exceeded the carrying value of long-lived assets, including goodwill, by approximately 23%.

The allocated goodwill balance related to our Ambulatory Care segment, consisting generally of assets acquired in 2015, totals approximately $3.243 billion.

The allocated goodwill balance related to our Conifer segment totals approximately $605 million. In our latest impairment analysis as of December 31, 2015, the estimated fair value of the Conifer segment exceeded the carrying value of long-lived assets, including goodwill, by approximately 134%.

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, 2013, we increased the valuation allowance by $51 million, $34 million due to the acquisition of Vanguard and $17 million primarily due to the recording of deferred tax assets for state net operating loss carryforwards that have a full valuation allowance. During the year ended December 31, 2014, we decreased the valuation allowance by $20 million primarily due to the expiration of unutilized state net operating loss carryovers. During the year ended December 31, 2015, we increased the valuation allowance by $9 million, $5 million due to the acquisition of USPI and $4 million due to changes in expected realizability of deferred tax assets, primarily related to unutilized state net operating loss carryforwards. The remaining balance in the valuation allowance as of December 31, 2015 is $96 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 table below presents information about certain of our market-sensitive financial instruments as of December 31, 2015. 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.

	Maturity Date, Years Ending December 31,							
	2016	2017	2018	2019	2020	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$127	$170	$1,128	$1,677	$3,410	$7,361	$13,873	$13,467
Average effective interest rates	6.7 %	7.1 %	6.6 %	5.5 %	6.7 %	7.2 %	6.8 %	
Variable rate long-term debt	$ —	$ —	$ —	$ —	$ 900	$ —	$ 900	$ 879
Average effective interest rates	—	—	—	—	4 %	— %	— %	

At December 31, 2015, the potential reduction of annual pretax earnings due to a one percentage point (100 basis point) increase in variable interest rates on long-term debt would be approximately $9 million.

At December 31, 2015, 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. Thus, 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.

Table of Contents

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, 2015. 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, 2015.

As more fully described under the heading "Description of Business" in Note 1 to the Consolidated Financial Statements in Item 8, we formed our USPI Holding Company, Inc. ("USPI joint venture") and acquired European Surgical Partners Ltd. ("Aspen") on June 16, 2015. We excluded our USPI joint venture and Aspen from our 2015 assessment of the effectiveness of our internal control over financial reporting. Our USPI joint venture and Aspen accounted for approximately 22% of total assets and 5% of net operating revenues of our consolidated financial statement amounts as of and for the year ended December 31, 2015. We expect that our internal control system will be fully implemented at our USPI joint venture and Aspen during 2016 and correspondingly evaluated by us for effectiveness.

Tenet's internal control over financial reporting as of December 31, 2015 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, 2015, 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/ TREVOR FETTER
Trevor Fetter
Chief Executive Officer and Chairman of the Board of Directors
February 22, 2016

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer
February 22, 2016

Table of Contents

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2015, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in Management's Report on Internal Control Over Financial Reporting, management excluded from its assessment the internal control over financial reporting at USPI Holding Company, Inc. and European Surgical Partners Ltd., which were formed and acquired

on June 16, 2015, and whose financial statements constitute 22% of total assets, and 5% of net operating revenues of the consolidated financial statement amounts as of and for the year ended December 31, 2015. Accordingly, our audit did not include the internal control over financial reporting at USPI Holding Company, Inc. and European Surgical Partners Ltd. 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 conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel 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 the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2015 of the Company and our report dated February 22, 2016 expressed an unqualified opinion on those consolidated financial statements and financial statement schedule and included an explanatory paragraph regarding the Company's adoption of new accounting standards.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 22, 2016

Table of Contents

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2015 and 2014, 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, 2015. Our audits also included the financial statement schedule listed in the Index at Item 15. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the consolidated financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Company at December 31, 2015 and 2014, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

As discussed in Note 1 to the consolidated financial statements, the Company has changed its method of accounting for presentation of deferred tax assets and presentation of debt issuance costs in the consolidated balance sheet as of December 31, 2014 due to the adoption of Accounting Standards Update (ASU) 2015-17, "Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes" and ASU 2015-03, "Interest–Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs."

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2015, based on the criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 22, 2016, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 22, 2016

Table of Contents

CONSOLIDATED BALANCE SHEETS
Dollars in Millions

	December 31, 2015	December 31, 2014
ASSETS		

Current assets:		
Cash and cash equivalents	$ 356	$ 193
Accounts receivable, less allowance for doubtful accounts ($887 at December 31, 2015 and $852 at December 31, 2014)	2,704	2,404
Inventories of supplies, at cost	309	276
Income tax receivable	7	2
Assets held for sale	550	2
Other current assets	1,245	1,093
Total current assets	**5,171**	**3,970**
Investments and other assets	1,175	384
Deferred income taxes	776	863
Property and equipment, at cost, less accumulated depreciation and amortization ($4,323 at December 31, 2015 and $4,478 at December 31, 2014)	7,915	7,733
Goodwill	6,970	3,913
Other intangible assets, at cost, less accumulated amortization ($659 at December 31, 2015 and $630 at December 31, 2014)	1,675	1,088
Total assets	**$ 23,682**	**$ 17,951**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 127	$ 112
Accounts payable	1,380	1,179
Accrued compensation and benefits	880	852
Professional and general liability reserves	177	189
Accrued interest payable	205	194
Liabilities held for sale	101	—
Accrued legal settlement costs	294	45
Other current liabilities	1,144	1,006
Total current liabilities	**4,308**	**3,577**
Long-term debt, net of current portion	14,383	11,505
Professional and general liability reserves	578	492
Defined benefit plan obligations	595	633
Other long-term liabilities	594	558
Total liabilities	**20,458**	**16,765**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	2,266	401
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 146,920,454 shares issued at December 31, 2015 and 145,578,735 shares issued at December 31, 2014	7	7
Additional paid-in capital	4,815	4,614
Accumulated other comprehensive loss	(164)	(182)
Accumulated deficit	(1,550)	(1,410)
Common stock in treasury, at cost, 48,425,298 shares at December 31, 2015 and 47,196,902 shares at December 31, 2014	(2,417)	(2,378)
Total shareholders' equity	**691**	**651**
Noncontrolling interests	**267**	**134**
Total equity	**958**	**785**
Total liabilities and equity	**$ 23,682**	**$ 17,951**

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2015	2014	2013
Net operating revenues:			
Net operating revenues before provision for doubtful accounts	$ 20,111	$ 17,908	$ 12,059
Less: Provision for doubtful accounts	1,477	1,305	972
Net operating revenues	**18,634**	**16,603**	**11,087**
Equity in earnings of unconsolidated affiliates	**99**	**12**	**15**
Operating expenses:			
Salaries, wages and benefits	9,011	8,023	5,371
Supplies	2,963	2,630	1,784
Other operating expenses, net	4,555	4,114	2,701
Electronic health record incentives	(72)	(104)	(96)
Depreciation and amortization	797	849	545
Impairment and restructuring charges, and acquisition-related costs	318	153	103
Litigation and investigation costs	291	25	31
Gains on sales, consolidation and deconsolidation of facilities	(186)	—	—
Operating income	**1,056**	**925**	**663**
Interest expense	(912)	(754)	(474)
Loss from early extinguishment of debt	(1)	(24)	(348)
Investment earnings	1	—	1
Net income (loss) from continuing operations, before income taxes	**144**	**147**	**(158)**
Income tax benefit (expense)	(68)	(49)	65
Net income (loss) from continuing operations, before discontinued operations	**76**	**98**	**(93)**
Discontinued operations:			
Loss from operations	(5)	(17)	(5)
Litigation and investigation costs	8	(18)	(2)
Income tax benefit (expense)	(1)	13	(4)
Net income (loss) from discontinued operations	**2**	**(22)**	**(11)**
Net income (loss)	**78**	**76**	**(104)**
Less: Net income attributable to noncontrolling interests	218	64	30
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ (140)**	**$ 12**	**$ (134)**
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders			
Net income (loss) from continuing operations, net of tax	$ (142)	$ 34	$ (123)
Net income (loss) from discontinued operations, net of tax	2	(22)	(11)
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ (140)**	**$ 12**	**$ (134)**
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ (1.43)	$ 0.35	$ (1.21)
Discontinued operations	0.02	(0.23)	(0.11)
	$ (1.41)	**$ 0.12**	**$ (1.32)**
Diluted			
Continuing operations	$ (1.43)	$ 0.34	$ (1.21)
Discontinued operations	0.02	(0.22)	(0.11)
	$ (1.41)	**$ 0.12**	**$ (1.32)**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	99,167	97,801	101,648
Diluted	99,167	100,287	101,648

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

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

	Years Ended December 31,		
	2015	2014	2013
Net income (loss)	$ 78	$ 76	$ (104)
Other comprehensive income (loss):			
Adjustments for defined benefit plans	3	(258)	62
Amortization of net actuarial loss included in net periodic benefit costs	12	4	7
Unrealized gains (losses) on securities held as available-for-sale	(2)	3	—
Foreign currency translation adjustments	5	—	—
Other comprehensive income (loss) before income taxes	**18**	**(251)**	**69**
Income tax benefit (expense) related to items of other comprehensive income (loss)	—	93	(25)
Total other comprehensive income (loss), net of tax	**18**	**(158)**	**44**
Comprehensive net income (loss)	**96**	**(82)**	**(60)**
Less: Comprehensive income attributable to noncontrolling interests	**218**	**64**	**30**
Comprehensive net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ (122)**	**$ (146)**	**$ (90)**

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

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

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock		Additional	Accumulated Other				
	Shares Outstanding	Issued Par Amount	Paid-in Capital	Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balance at December 31, 2012	104,633	$ 7	$ 4,471	$ (68)	$ (1,288)	$ (1,979)	$ 75	$ 1,218
Net income (loss)	—	—	—	—	(134)	—	21	(113)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(22)	(22)
Other comprehensive income	—	—	—	44	—	—	—	44
Contributions from noncontrolling interests	—	—	56	—	—	—	49	105
Repurchases of common stock	(9,485)	—	—	—	—	(400)	—	(400)
Stock-based compensation expense and issuance of common stock	1,712	—	45	—	—	1	—	46
	96,860	7	4,572	(24)	(1,422)	(2,378)	123	878

Balance at December 31, 2013		$	$	$	$	$	$	$
Net income	—	—	—	—	12	—	31	43
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(37)	(37)
Contributions from noncontrolling interests	—	—	—	—	—	—	7	7
Other comprehensive income	—	—	—	(158)	—	—	—	(158)
Purchases (sales) of businesses and noncontrolling interests	—	—	(22)	—	—	—	10	(12)
Stock-based compensation expense and issuance of common stock	1,522	—	64	—	—	—	—	64
Balances at December 31, 2014	98,382	$ 7	$ 4,614	$ (182)	$ (1,410)	$ (2,378)	$ 134	$ 785
Net income (loss)	—	—	—	—	(140)	—	52	(88)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(50)	(50)
Contributions from noncontrolling interests	—	—	—	—	—	—	3	3
Other comprehensive income	—	—	—	18	—	—	—	18
Purchases (sales) of businesses and noncontrolling interests	—	—	124	—	—	—	128	252
Repurchases of common stock	(1,243)	—	—	—	—	(40)	—	(40)
Stock-based compensation expense and issuance of common stock	1,356	—	77	—	—	1	—	78
Balances at December 31, 2015	98,495	$ 7	$ 4,815	$ (164)	$ (1,550)	$ (2,417)	$ 267	$ 958

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2015	2014	2013
Net income (loss)	$ 78	$ 76	$ (104)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	797	849	545
Provision for doubtful accounts	1,477	1,305	972
Deferred income tax expense (benefit)	42	30	(67)
Stock-based compensation expense	69	51	36
Impairment and restructuring charges, and acquisition-related costs	318	153	103
Litigation and investigation costs	291	25	31

Loss from early extinguishment of debt	1	24	348
Gains on sales, consolidation and deconsolidation of facilities	(186)	—	—
Undistributed earnings from affiliates	(99)	(10)	(13)
Amortization of debt discount and debt issuance costs	41	28	19
Pre-tax loss (income) from discontinued operations	(3)	35	7
Other items, net	59	(30)	(20)
Changes in cash from operating assets and liabilities:			
Accounts receivable	(1,632)	(1,896)	(987)
Inventories and other current assets	(130)	(314)	(203)
Income taxes	18	3	—
Accounts payable, accrued expenses and other current liabilities	68	505	38
Other long-term liabilities	38	44	13
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(200)**	**(168)**	**(114)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(21)**	**(23)**	**(15)**
Net cash provided by operating activities	**1,026**	**687**	**589**
Cash flows from investing activities:			
Purchases of property and equipment — continuing operations	(842)	(933)	(691)
Purchases of businesses or joint venture interests, net of cash acquired	(940)	(428)	(1,515)
Proceeds from sales of facilities and other assets	549	6	20
Proceeds from sales of marketable securities, long-term investments and other assets	60	13	12
Purchases of equity investments	(134)	(12)	(1)
Other long-term assets	(4)	31	8
Other items, net	(6)	1	3
Net cash used in investing activities	**(1,317)**	**(1,322)**	**(2,164)**
Cash flows from financing activities:			
Repayments of borrowings under credit facility	(2,815)	(2,430)	(1,286)
Proceeds from borrowings under credit facility	2,595	2,245	1,691
Repayments of other borrowings	(2,049)	(683)	(5,133)
Proceeds from other borrowings	3,158	1,608	6,507
Repurchases of common stock	(40)	—	(400)
Debt issuance costs	(80)	(27)	(154)
Distributions paid to noncontrolling interests	(110)	(45)	(27)
Contributions from noncontrolling interests	4	18	99
Purchase of noncontrolling interests	(254)	—	—
Proceeds from exercise of stock options	15	26	22
Other items, net	30	3	5
Net cash provided by financing activities	**454**	**715**	**1,324**
Net increase (decrease) in cash and cash equivalents	163	80	(251)
Cash and cash equivalents at beginning of period	193	113	364
Cash and cash equivalents at end of period	**$ 356**	**$ 193**	**$ 113**
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (859)	$ (726)	$ (426)
Income tax payments, net	$ (7)	$ (8)	$ (6)

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

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, 2015, we operated 86 hospitals, 20 short-stay surgical hospitals, over 475 outpatient centers, and nine facilities in the United Kingdom through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI joint venture"). The results of 146 of these facilities, in which we hold noncontrolling interests, are recorded using the equity method of accounting. Our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into our new USPI joint venture. We also refinanced approximately $1.5 billion of existing USPI debt and paid approximately $424 million to align the respective valuations of the assets contributed to the joint venture. We currently own 50.1% of the USPI joint venture. In addition, we completed the acquisition of European Surgical Partners Ltd. ("Aspen") for approximately $226 million on June 16, 2015. Aspen has nine private hospitals and clinics in the United Kingdom.

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 December 31, 2015, we adopted Accounting Standards Update ("ASU") 2015-03, "Interest–Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs," which requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, and ASU 2015-17, "Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes," which requires that deferred tax liabilities and assets be classified as noncurrent in a classified balance sheet. All periods presented have been reclassified to reflect retrospective adoption in accordance with the provisions of ASU 2015-03 and ASU 2015-17. The adoption of ASU 2015-03 resulted in a decrease in other intangible assets and long-term debt, net of current portion, of $190 million in the accompanying Consolidated Balance Sheet at December 31, 2014. The adoption of ASU 2015-17 resulted in a decrease in current portion of deferred income taxes and an increase in deferred income taxes of $747 million in the accompanying Consolidated Balance Sheet at December 31, 2014.

The accompanying Notes and related amounts have been recasted to reflect the formation of Ambulatory Care segment. The facilities we contributed to our new USPI joint venture were moved to the new Ambulatory Care segment. Certain prior-year amounts have also been reclassified to conform to current-year presentation.

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

Table of Contents

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

The accounts of Aspen 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 are accumulated in shareholders' equity.

Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, 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.

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 recorded by us could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording 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. Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2015, 2014 and 2013 by $64 million, $20 million, and $38 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

Table of Contents

adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

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. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our 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 provision for doubtful accounts 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 for in the accompanying Consolidated Financial Statements.

Under our Compact or 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 through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

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

The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Years Ended December 31,		
	2015	2014	2013
General Hospitals:			
Medicare	$ 3,403	$ 3,395	$ 2,319
Medicaid	1,451	1,482	971
Managed care	10,098	9,027	6,140
Indemnity, self-pay and other	1,726	1,561	1,162
Acute care hospitals — other revenue	63	53	63
Other:			

Other operations	3,370	2,390	1,404
Net operating revenues before provision for doubtful accounts	**$ 20,111**	**$ 17,908**	**$ 12,059**

Table of Contents

Provision for Doubtful Accounts

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws 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 provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. 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.

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. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. Hospitals that are meaningful users under the Medicare EHR incentive payment program are deemed meaningful users under the Medicaid EHR incentive payment program and do not need to meet additional criteria imposed by a state. Medicaid EHR incentive payments to providers are 100% federally funded and administered by the states. The Centers for Medicare and Medicaid Services ("CMS") established calendar year 2011 as the first year states could offer EHR

incentive payments. Before a state may offer EHR incentive payments, the state must submit and CMS must approve the state's incentive plan.

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, 2015, 2014 and 2013, certain of our hospitals and physicians satisfied the CMS AIU and/or meaningful use criteria. As a result, we recognized approximately $72 million, $104 million and $96 million of Medicare and

Table of Contents

Medicaid EHR incentive payments as a reduction to expense in our Consolidated Statement of Operations for the years ended December 31, 2015, 2014 and 2013, 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 approximately $356 million and $193 million at December 31, 2015 and 2014, respectively. As of December 31, 2015 and 2014, our book overdrafts were approximately $301 million and $264 million, respectively, which were classified as accounts payable.

At December 31, 2015 and 2014, approximately $171 million and $157 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 health plans.

Also at December 31, 2015 and 2014, we had $133 million and $150 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $95 million and $112 million, respectively, were included in accounts payable.

During the years ended December 31, 2015 and 2014, we entered into non-cancellable capital leases of approximately $162 million and $173 million, respectively, primarily for buildings and equipment.

Investments in Debt and Equity Securities

We classify investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2015 and 2014, we had no significant investments in securities classified as either held-to-maturity or trading. We carry 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 include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Investments in Unconsolidated Affiliates

We control 194 of the facilities operated by our Ambulatory Care segment and, therefore, consolidate their results (192 are consolidated within our Ambulatory Care segment and two are consolidated within our Hospital Operations and other segment). We account for many of the facilities our Ambulatory Care segment operates (139 of 333 at December 31, 2015) under the equity method as investments in unconsolidated affiliates and report only our share of net income attributable to the investee as equity in earnings of unconsolidated affiliates in the accompanying Condensed Consolidated

Statements of Operations. Summarized financial information for our equity method investees is included in the following table. For investments acquired during the reported periods, amounts reflect 100% of the investee's results beginning on the date of our acquisition of the investment.

	December 31, 2015
Current assets	$ 866
Noncurrent assets	$ 854
Current liabilities	$ (301)
Noncurrent liabilities	$ (377)
Noncontrolling interests	$ (309)

	Year Ended December 31, 2015
Net operating revenues	$ 1,335
Net income	$ 436
Net income attributable to the investee	$ 356

Table of Contents

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, 2015, 2014 and 2013, capitalized interest was $12 million, $25 million and $14 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, 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 2.09% at December 31, 2015 and 1.97% at December 31, 2014. 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.

Table of Contents

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 general hospitals generated 83%, 87% and 88% of our net operating revenues before provision for doubtful accounts in the years ended December 31, 2015, 2014 and 2013, respectively. Each of our operating regions and markets related to our general hospitals report directly to our president of hospital operations. Major decisions, including capital resource allocations, are made at the consolidated level, not at the regional, market or hospital level.

Our core business is Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, urgent care centers, freestanding emergency departments, physician practices and health plans. In the three months ended June 30, 2015, we began reporting Ambulatory Care as a separate reportable business segment. Previously, our business consisted of our Hospital Operations and other segment and our Conifer segment, which provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

Effective June 16, 2015, we completed the joint venture transaction that combined our freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets. We contributed our interests in

Table of Contents

49 ambulatory surgery centers and 20 imaging centers, which had previously been included in our Hospital Operations and other segment, to the joint venture. The USPI joint venture has interests in 249 ambulatory surgery centers, 20 short-stay surgical hospitals, 20 imaging centers and 35 urgent care centers in 28 states. We also completed the acquisition of Aspen effective June 16, 2015, which includes nine private hospitals and clinics in the United Kingdom. Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and Aspen facilities. 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

Share Repurchase Programs

In November 2015, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expires in December 2016. Under the program, shares may be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations. The program may be

suspended for periods or discontinued at any time. The timing and amount of repurchase transactions will be based on an evaluation of market conditions, share purchase prices, the timing of divestiture proceeds and other factors. Pursuant to the share repurchase program, we paid approximately $40 million to repurchase a total of 1,242,806 shares during the period from the commencement of the program through December 31, 2015.

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
November 1, 2015 through November 30, 2015	978	$ 32.71	978	$ 468
December 1, 2015 through December 31, 2015	265	30.25	265	460
November 1, 2015 through December 31, 2015	**1,243**	**$ 32.18**	**1,243**	**$ 460**

In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase

Table of Contents

program, we paid approximately $500 million to repurchase a total of 12,891,298 shares during the period from the commencement of the program through December 31, 2013.

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
November 1, 2012 through December 31, 2012	**3,406**	**$ 29.36**	**3,406**	**$ 400**
January 1, 2013 through January 31, 2013	531	37.13	531	380
February 1, 2013 through February 28, 2013	914	39.30	914	344
March 1, 2013 through March 31, 2013	1,010	43.95	1,010	300
Three Months Ended March 31, 2013	**2,455**	**40.74**	**2,455**	**300**
May 1, 2013 through May 31, 2013	933	46.78	933	256
June 1, 2013 through June 30, 2013	1,065	45.71	1,065	208
Three Months Ended June 30, 2013	**1,998**	**46.21**	**1,998**	**208**
	166	46.08	166	200

July 1, 2013 through July 31, 2013				
August 1, 2013 through August 31, 2013	1,045	40.43	1,045	158
September 1, 2013 through September 30, 2013	1,431	40.35	1,431	100
Three Months Ended September 30, 2013	**2,642**	**40.75**	**2,642**	**100**
November 1, 2013 through November 30, 2013	796	42.28	796	66
December 1, 2013 through December 31, 2013	1,594	41.62	1,594	—
Three Months Ended December 31, 2013	**2,390**	**41.84**	**2,390**	—
Total	**12,891**	**$ 38.79**	**12,891**	**$ —**

Repurchased shares are recorded based on settlement date and are held as treasury stock.

NOTE 3. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

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

	December 31, 2015	December 31, 2014
Continuing operations:		
Patient accounts receivable	$ 3,486	$ 3,178
Allowance for doubtful accounts	(887)	(851)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	144	125
Net cost reports and settlements payable and valuation allowances	(42)	(51)
	2,701	2,401
Discontinued operations	3	3
Accounts receivable, net	**$ 2,704**	**$ 2,404**

At December 31, 2015 and 2014, our allowance for doubtful accounts was 25.4% and 26.8%, respectively, of our patient accounts receivable. Our allowance was impacted by higher patient co–pays and deductibles, partially offset by a decline in uninsured revenues due to the expansion of insurance coverage under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. Additionally, the composition of our accounts receivable has been impacted by our acquisition and divestiture activity.

Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate 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, 2015 and 2014, our allowance for doubtful accounts

Table of Contents

for self-pay was 80.6% and 78.0%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. At December 31, 2015 and 2014, our allowance for doubtful accounts for managed care was 7.5% and 6.5%, respectively, of our managed care patient accounts receivable.

Accounts assigned to our Conifer subsidiary are written off and excluded from patient accounts receivable and allowance for doubtful accounts; however, an estimate of future recoveries from all accounts at our Conifer subsidiary is determined based on historical experience and recorded on our hospitals' books as a component of accounts receivable in the accompanying Consolidated Balance Sheets. At the present time, our new acquisitions have not yet been fully integrated into our Conifer collections processes.

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) 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 for charity care patients and self-pay patients, as well as DSH payments we received, for the years ended December 31, 2015, 2014 and 2013.

	Years Ended December 31,		
	2015	2014	2013
Estimated costs for:			
Self-pay patients	$ 678	$ 620	$ 545
Charity care patients	$ 191	$ 180	$ 158
DSH and other supplemental revenues	$ 888	$ 817	$ 428

As of December 31, 2015 and 2014, we had approximately $387 million and $399 million, respectively, of receivables recorded in other current assets and approximately $139 million and $212 million, respectively, of payables recorded in other current liabilities in the accompanying Consolidated Balance Sheets related to California's provider fee program.

NOTE 4. ASSETS AND LIABILITIES HELD FOR SALE

In the three months ended June 30, 2015, we entered into a definitive agreement for the sale of the assets of our Saint Louis University Hospital ("SLUH") to Saint Louis University. In accordance with the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," we classified SLUH's assets as "assets held for sale" in current assets and SLUH's liabilities as "liabilities held for sale" in current liabilities in our Consolidated Balance Sheet at June 30, 2015. These assets and liabilities were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. As a result of this anticipated transaction, we recorded an impairment charge of $147 million 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, 2015. We completed the sale of SLUH on August 31, 2015 at a transaction price of approximately $32 million, excluding working capital and subject to customary purchase price adjustments. Because we did not sell SLUH's accounts receivable related to the pre-closing period, net receivables of approximately $32 million are included in accounts receivable, less allowance for doubtful accounts, in the accompanying Consolidated Balance Sheet at December 31, 2015.

Our hospitals, physician practices and related assets in North Carolina also met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. We completed the sale of our North Carolina assets on December 31, 2015 at a transaction price of approximately $191 million and recognized a gain on sale of approximately $3 million. Because we did not sell the related accounts receivable related to the pre-closing period, net receivables of

Table of Contents

approximately $45 million are included in accounts receivable, less allowance for doubtful accounts in the accompanying Consolidated Balance Sheet at December 31, 2015.

During the three months ended March 31, 2015, we entered into a definitive agreement to form two joint ventures with Baylor Scott & White Health involving the ownership and operation of Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center and Texas Regional Medical Center at Sunnyvale (collectively, "our North Texas hospitals") – which were operated by certain of our subsidiaries – and Baylor Medical Center at Garland – which was owned and operated by Baylor Scott & White Health, which will hold a majority ownership interest in the joint ventures. The transactions closed on December 31, 2015 at a net transaction price of approximately $288 million, and we recorded a gain on deconsolidation of these facilities of approximately $151 million. We also recorded an equity investment in the new joint ventures of approximately $164 million, which included $11 million of cash contributed at closing.

Our hospitals, physician practices and related assets in Georgia also met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. In accordance with the guidance in ASC 360, we have classified $549 million of our assets in Georgia as "assets held for sale" in current assets and $101 million of our liabilities in Georgia as "liabilities held for sale" in current liabilities in the accompanying Consolidated Balance Sheet at December 31, 2015. These assets and liabilities were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. There were no impairment charges recorded as a result of these anticipated transactions. These transactions are subject to the execution of definitive asset sales agreements and customary closing conditions, including regulatory approvals.

Assets and liabilities classified as held for sale at December 31, 2015, all of which were in the Hospital Operations and other segment, were comprised of the following:

Other current assets	$ 14
Property and equipment	401
Other long-term assets	135
Current liabilities	(10)
Long-term liabilities	(91)
Net assets held for sale	**$ 449**

NOTE 5. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

We recognized impairment charges on long-lived assets in 2015, 2014 and 2013 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 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, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI. As of

December 31, 2015, our continuing operations consisted of three reportable segments, our Hospital Operations and other, Ambulatory Care and Conifer. During the three months ended June 30, 2015, within our Hospital Operations and other segment, we combined our Central region with our

Table of Contents

Resolute Health, San Antonio and South Texas markets to create our new Texas region, and we moved our hospitals and other operations in Tennessee from our Texas region to our Southern region. Our Hospital Operations and other segment is currently structured as follows:

- Our Texas region included all of our hospitals and other operations in Missouri, New Mexico and Texas;
- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region included all of our hospitals and other operations in Alabama, Georgia, South Carolina and Tennessee;
- Our Western region included all of our hospitals and other operations in Arizona and California; and
- Our Detroit market included all of our hospitals and other operations in the Detroit, Michigan area.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

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, 2015

During the year ended December 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $318 million, including $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 4. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. Material adverse trends in our estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improves to the extent that the estimated future undiscounted cash flows exceeds the carrying value of the long-lived assets, these hospitals are at

risk of future impairments. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million related to investments. We also recorded $25 million of employee severance costs, $6 million of restructuring costs, $19 million of contract and lease termination fees, and $100 million in acquisition-related costs, which include $55 million of transaction costs and $45 million of acquisition integration charges.

Year Ended December 31, 2014

During the year ended December 31, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $153 million. This amount included a $20 million impairment charge for the write-down of buildings and

Table of Contents

equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment declines. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $23 million as of December 31, 2014 after recording the impairment charge. We also recorded $16 million of employee severance costs, $19 million of contract and lease termination fees, $3 million of restructuring costs, and $95 million in acquisition-related costs, which include $16 million of transaction costs and $79 million of acquisition integration charges.

Year Ended December 31, 2013

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors contributing to the adverse financial trends at that time 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 hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. We disclosed in our Annual Report on Form 10-K for the year ended December 31, 2013 that, unless the anticipated future financial trends of this hospital improved to the

extent that the estimated future undiscounted cash flows exceeded the carrying value of the long-lived assets, this hospital was at risk of future impairments, which impairments occurred in 2014 as described above, particularly if we spent significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment declined. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination fees, and $59 million in acquisition-related costs, which included both transaction costs and acquisition integration charges.

NOTE 6. SHORT-TERM BORROWINGS AND LONG-TERM DEBT AND LEASE OBLIGATIONS

Interim Loan Agreement

During the three months ended March 31, 2015, we entered into a new interim loan agreement (the "Interim Loan Agreement") providing for a 364-day secured term loan facility in the aggregate principal amount of $400 million. On June 16, 2015, we repaid the $400 million aggregate principal amount of the term loan (plus accrued interest of $1 million) outstanding under the Interim Loan Agreement as of that day. We had used the proceeds of the term loan (i) to repay outstanding obligations under our Credit Agreement (defined below), and (ii) to pay certain costs, fees and expenses

Table of Contents

incurred in connection with entering into the Interim Loan Agreement. Amounts borrowed under the Interim Loan Agreement and repaid or prepaid may not be reborrowed. As a result, the Interim Loan Agreement was terminated as of June 16, 2015.

Long-Term Debt and Lease Obligations

The table below shows our long-term debt as of December 31, 2015 and 2014:

	December 31, 2015	December 31, 2014
Senior notes:		
5%, due 2019	$ 1,100	$ 1,100
5½%, due 2019	500	500
6¾%, due 2020	300	300
8%, due 2020	750	750
8⅛%, due 2022	2,800	2,800
6¾%, due 2023	1,900	—
6⅞%, due 2031	430	430
Senior secured notes:		
6¼%, due 2018	1,041	1,041
4¾%, due 2020	500	500
6%, due 2020	1,800	1,800
Floating % due 2020	900	—
4½%, due 2021	850	850
4⅜%, due 2021	1,050	1,050
Credit facility due 2020	—	220
Capital leases and mortgage notes	852	487
Unamortized issue costs, note discounts and premium	(263)	(211)
Total long-term debt	**14,510**	**11,617**
Less current portion	127	112
Long-term debt, net of current portion	**$ 14,383**	**$ 11,505**

Credit Agreement

On December 4, 2015, we entered into an amendment to our existing senior secured revolving credit facility (as amended, "Credit Agreement") in order to, among other things, extend the scheduled maturity date of the facility, reduce the rates of certain interest and fees payable under the facility and remove certain restrictions with respect to the borrowing base eligibility of certain account receivable. The Credit Agreement 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. As of December 31, 2015, we were in compliance with all covenants and conditions in our Credit Agreement. The Credit Agreement, which has a scheduled maturity date of December 4, 2020, is collateralized by patient accounts receivable of substantially all of our domestic wholly owned hospitals. In addition, borrowings under the Credit Agreement are guaranteed by substantially all of our wholly owned domestic hospital subsidiaries. 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, 2015, we had no cash borrowings outstanding under the revolving credit facility and we had approximately $5 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $995 million was available for borrowing under the revolving credit facility at December 31, 2015.

Table of Contents

Letter of Credit Facility

On March 7, 2014, we entered into a new letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our existing Credit Agreement, which we transferred to the LC Facility (the "Existing 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 LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by 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.

Drawings under any letter of credit issued under the LC Facility (including the Existing Letters of Credit) that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.875% per annum. An unused commitment fee is payable at an initial rate of 0.50% per annum with a step down to 0.375% per annum based on the secured debt to EBITDA ratio of 3.00 to 1.00. A per annum fee on the aggregate outstanding amount of issued but undrawn letters of credit (including Existing Letters of Credit) will accrue at a rate of 1.875% 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, 2015, we had approximately $105 million of standby letters of credit outstanding under the LC Facility.

Senior Notes and Senior Secured Notes

In June 2015, we sold $900 million aggregate principal amount of floating rate senior secured notes, which will mature on June 15, 2020 (the "Secured Notes"), and assumed $1.9 billion aggregate principal amount of $6^3/_4$% senior notes, which will mature on June 15, 2023 (the "Unsecured Notes" and, together with the Secured Notes, the "Notes"), issued by THC Escrow Corporation II. We will pay interest on the Secured Notes quarterly in arrears on March 15, June 15, September 15 and December 15 of each year, which payments commenced on September 15, 2015. The Secured Notes accrue interest at

a rate per annum, reset quarterly, equal to LIBOR plus 3½%. We will pay interest on the Unsecured Notes semi-annually in arrears on June 15 and December 15 of each year, commencing on December 15, 2015. The proceeds from the sale of the Notes were used to repay borrowings outstanding under our Interim Loan Agreement and Credit Agreement, as well as to refinance the debt of USPI and to pay the cash consideration in respect of our USPI joint venture and Aspen acquisition.

In September 2014, we sold $500 million aggregate principal amount of 5½% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, commencing on March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 9¼% senior notes due 2015 in July 2014. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $24 million, 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. The net proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement.

In October 2013, we sold $2.8 billion aggregate principal amount of 8⅛% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8⅛% senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard.

Table of Contents

In May 2013, we sold $1.050 billion aggregate principal amount of 4⅜% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4⅜% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, which payments commenced on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately $767 million aggregate principal amount outstanding of our 8⅞% senior secured notes due 2019 in a tender offer and to call approximately $158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold $850 million aggregate principal amount of 4½% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4½% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately $645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately $69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $177 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs. The remaining net proceeds were used for general corporate purposes, including the repayment of borrowings under our senior secured revolving credit facility.

All of our senior 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 below, the obligations of our subsidiaries and any obligations under our Credit Agreement to the extent of the collateral. We may redeem any series of our senior 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, together with accrued and unpaid interest to the redemption date.

All of our senior secured notes are guaranteed by certain of our hospital company subsidiaries and secured by a first-priority pledge of the capital stock and other ownership interests of those subsidiaries. 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.

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.

Covenants

Credit Agreement. Our Credit Agreement contains customary covenants for an asset-backed facility, including a minimum fixed charge coverage ratio to be met when 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

Table of Contents

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.

Unsecured Senior Notes. The indentures governing our senior 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 indentures as a hospital that has an asset value on our books in excess of 5% of our consolidated net tangible assets, as defined. 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 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.

Unsecured Notes. The indenture governing the Unsecured Notes contains covenants and terms (including terms regarding mandatory and optional redemption) that are similar to those in the indentures governing our unsecured senior notes described above. 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 and the LC Facility to the extent of the collateral.

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 important 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 greater of (i) $3.2 billion or (ii) the amount that would cause the secured debt ratio (as defined in the indentures) to exceed 4.0 to 1.0; provided that the aggregate amount of all such debt secured by a lien on par to the lien securing the senior secured notes may not exceed the greater of (a) $2.6 billion or (b) the amount that would cause the secured debt ratio to exceed 3.0 to 1.0.

Secured Notes. The indenture governing the Secured Notes contains covenants and terms (including terms regarding mandatory redemption) that are similar to those in the indentures governing our senior secured notes described above, except we are permitted under the indenture governing the Secured Notes to incur secured debt so long as, 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 Secured Notes outstanding at such time) does not exceed the greater of (i) $8.5 billion or (ii) the amount that would cause the secured debt ratio (as defined in the indenture) to exceed 4.0 to 1.0 and, provided further, that the aggregate amount of all such debt secured by a lien on par to the lien securing the Secured Notes does not exceed the greater of (a) $6.4 billion or (b) the amount that would cause the secured debt ratio to exceed 3.0 to 1.0. In addition, pursuant to the Secured Notes indenture, we may, at our option, redeem the Secured Notes, in whole or in part, at any time prior to June 15, 2016 at a redemption price equal to 100% of the principal amount of the notes being redeemed plus the make-whole premium set forth in the Secured Notes indenture, together with accrued and unpaid interest thereon, if any, to the redemption date. From and after June 15, 2016, we may, at our option, redeem the Secured Notes in whole or in part at the redemption prices specified in the Secured Notes indenture.

All of our senior secured notes are guaranteed by certain of our domestic hospital company subsidiaries and secured by a first-priority pledge of the capital stock and other ownership interests of those subsidiaries. All of our senior

Table of Contents

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 and the LC Facility to the extent of the

value of the collateral securing borrowings thereunder; and they are structurally subordinated to all obligations of our nonguarantor subsidiaries.

Future Maturities

Future long-term debt maturities and minimum operating lease payments as of December 31, 2015 are as follows:

		Years Ending December 31,					Later
	Total	2016	2017	2018	2019	2020	Years
Long-term debt, including capital lease obligations	$14,978	$142	$154	$1,112	$1,661	$4,294	$7,615
Long-term non-cancelable operating leases	$ 1,213	$205	$175	$ 149	$ 122	$ 103	$ 459

Rental expense under operating leases, including short-term leases, was $292 million, $242 million and $186 million in the years ended December 31, 2015, 2014 and 2013, respectively. Included in rental expense for each of these periods was sublease income of $12 million, $9 million and $8 million, respectively, which were recorded as a reduction to rental expense.

NOTE 7. 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, 2015, 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 $100 million. We had a liability of $82 million recorded for these guarantees included in other current liabilities at December 31, 2015.

At December 31, 2015, 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 $35 million. Of the total, $17 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Consolidated Balance Sheet at December 31, 2015.

NOTE 8. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

We currently grant stock-based awards to our directors and key employees pursuant to our 2008 Stock Incentive Plan, which was approved by our shareholders at their 2008 annual meeting. At December 31, 2015, approximately 3.4 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock

option grants and other incentive awards, including restricted stock units. 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 or the equivalent value in cash in the future. Options and restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, from time to time, we grant performance-based options and restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe.

Our income from continuing operations for the years ended December 31, 2015, 2014 and 2013 includes $77 million, $51 million and $39 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements ($48 million, $32 million and $24 million, respectively, after-tax). The table below shows certain stock option and restricted stock unit grants and other awards that comprise the $77 million of stock-based compensation expense recorded in salaries, wages and benefits in the year ended December 31, 2015. 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, 2015
	(In Thousands)			(In Millions)
Stock Options:				
February 28, 2013	278	$ 39.31	$ 14.46	$ 1
Restricted Stock Units:				
May 8, 2015	44		37.06	2
February 25, 2015	1,573		45.63	22
August 25, 2014	673		59.90	9
February 26, 2014	1,329		44.12	22
June 13, 2013	318		47.13	3
February 28, 2013	842		39.31	11
Other grants				7
				$ 77

Prior to our shareholders approving the 2008 Stock Incentive Plan, we granted stock-based awards to our directors and employees pursuant to other plans. Stock options remain outstanding under those other plans, but no additional stock-based awards will be granted under them.

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

Table of Contents

Stock Options

The following table summarizes stock option activity during the years ended December 31, 2015, 2014 and 2013:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value	Weighted Average Remaining Life
			(In Millions)	
Outstanding at December 31, 2012	4,289,192	$ 30.49		

Granted	295,639		39.41			
Exercised	(946,086)		23.34			
Forfeited/Expired	(330,634)		55.79			
Outstanding at December 31, 2013	3,308,111	$	30.79			
Granted	—					
Exercised	(699,910)		33.53			
Forfeited/Expired	(624,052)		47.97			
Outstanding at December 31, 2014	1,984,149	$	24.42			
Granted	—		—			
Exercised	(340,869)		29.85			
Forfeited/Expired	(36,438)		42.08			
Outstanding at December 31, 2015	**1,606,842**	**$**	**22.87**	**$**	**14**	**3.2 years**
Vested and expected to vest at December 31, 2015	**1,605,971**	**$**	**22.86**	**$**	**14**	**3.2 years**
Exercisable at December 31, 2015	**1,328,391**	**$**	**19.42**	**$**	**14**	**3.4 years**

There were 340,869 stock options exercised during the year ended December 31, 2015 with a $8 million aggregate intrinsic value, and 699,910 stock options exercised in 2014 with a $13 million aggregate intrinsic value.

As of December 31, 2015, there were less than $1 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of one month.

In the years ended December 31, 2015, and 2014 there were no stock options granted.

The weighted average estimated fair value of stock options we granted in the year ended December 31, 2013 was $14.46 per share. These fair values were calculated based on each grant date, using a binomial lattice model with the following assumptions:

	Year Ended December 31, 2013
Expected volatility	50%
Expected dividend yield	0%
Expected life	3.6 years
Expected forfeiture rate	6%
Risk-free interest rate	0.48%
Early exercise threshold	100% gain
Early exercise rate	50% per year

The expected volatility used in the binomial lattice model incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price on two dates (one in 2010 and one in 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from the output of the binomial lattice model and represents the period of time that the options are expected to be outstanding. This model

Table of Contents

incorporates an early exercise assumption in the event of a significant increase in stock price. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise timeframes.

The following table summarizes information about our outstanding stock options at December 31, 2015:

	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	206,102	3.1 years	$ 4.56	206,102	$ 4.56
$4.57 to $25.089	910,897	4.0 years	20.99	910,897	20.99
$25.09 to $32.569	211,392	1.0 years	27.14	211,392	27.14
$32.57 to $42.529	278,451	2.2 years	39.31	—	—
	1,606,842	**3.2 years**	**$ 22.87**	**1,328,391**	**$ 19.42**

As of December 31, 2015, approximately 96.1% of all our outstanding options were held by current employees and approximately 3.9% were held by former employees. Approximately 80.8% of our outstanding options were in-the-money, that is, they had exercise price less than the $30.30 market price of our common stock on December 31, 2015, and approximately 19.2% were out-of-the-money, that is, they had an exercise price of more than $30.30 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	1,254,297	96.6 %	289,986	— %	1,544,283	96.1 %
Former employees	44,702	3.4 %	17,857	5.8 %	62,559	3.9 %
Totals	1,298,999	100.0 %	307,843	5.8 %	1,606,842	100.0 %
% of all outstanding options	80.8 %		19.2 %		100.0 %	

Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2015, 2014 and 2013:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2012	2,295,942	$ 23.40
Granted	1,564,224	41.20
Vested	(966,838)	24.20
Forfeited	(186,106)	29.69
Unvested at December 31, 2013	2,707,222	$ 33.34
Granted	1,772,276	48.42
Vested	(1,009,927)	27.49
Forfeited	(169,851)	36.64
Unvested at December 31, 2014	3,299,720	$ 40.99
Granted	1,718,057	45.51
Vested	(1,210,159)	38.40
Forfeited	(180,386)	42.46
Unvested at December 31, 2015	**3,627,232**	**$ 44.69**

In the year ended December 31, 2015, we granted 1,142,230 restricted stock units subject to time-vesting of which 1,067,383 will vest and be settled ratably over a three-year period from the date of the grant and 31,000 will vest 100% on the fifth anniversary of the grant date. In addition, in May 2015, we made an annual grant of 43,847 restricted stock units to our non-employee directors for the 2015-2016 board service year, which units vested immediately and will

Table of Contents

settle in shares of our common stock on the third anniversary of the date of the grant. In March 2015, following the appointment of a new member of our Board of Directors, we made an initial grant of 1,311 restricted stock units to that director, which units vested immediately, but will not settle until her separation from the Board, as well as a prorated annual grant of 526 restricted stock units for the 2014-2015 board service year, which units vested immediately, but will not settle until the earlier of three years from the date of grant or her separation from the board. Also, we granted 306,968 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of a specified one-year performance goal for the year ending December 31, 2015. The performance-based restricted stock units will vest ratably over a three-year period from the grant date. Based on our level of achievement with respect to the target performance goal for the year ended December 31, 2015, the performance-based restricted stock units will be granted at 165% of the initial grant and will vest ratably over a three-year period from the grant date.

In the year ended December 31, 2014, we granted 1,046,910 restricted stock units subject to time-vesting, of which 945,409 will vest and be settled ratably over a three-year period from the grant date and 23,435 will vest 100% on the tenth anniversary of the grant date, 63,623 will vest 100% on the fifth anniversary of the grant date and 14,443 will vest 100% on the third anniversary of the grant date. In addition, our newly appointed Board of Director member received an initial grant of 1,240 restricted stock units that immediately vested but will not settle until her separation from the board and an annual grant of 1,368 restricted stock units that immediately vested but will not settle until the earlier of three years or her separation from the board. We also granted 450,943 special retention restricted stock units to a select group of officers: two-thirds of the award will vest contingent on our achievement of a performance goal of which one-half will vest based on performance over one-year period ending in December 2015 (these grants met the 140% range) and the remaining one-half will vest based on performance over a four-year period ending in December 2018. The remaining one-third of this special retention award will vest in full on the fifth anniversary of the grant date. In addition, we granted 271,815 performance-based restricted stock units to certain of our senior officers. Based on our level of achievement with respect to the target performance goal for the year ended December 31, 2014, a total of 538,837 performance-based restricted stock units (or 200% of the initial grant) will vest ratably over a three-year period from the grant date.

As of December 31, 2015, there were $117 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.3 years.

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, 2015, there were approximately 70,363 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, 2015, 2014 and 2013:

	Years Ended December 31,		
	2015	2014	2013
Number of shares	145,290	162,128	100,217
Weighted average price	$ 43.96	$ 46.91	$ 42.88

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

Table of Contents

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 plan, were approximately $105 million, $92 million and $35 million for the years ended December 31, 2015, 2014 and 2013, 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. One of these SERPs was frozen during the year ended December 31, 2014. 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 on October 1, 2013, we assumed a frozen qualified defined benefit plan ("DMC Pension Plan") covering substantially all of the employees of our Detroit market that were hired prior to June 1, 2003. The benefits paid under the DMC Pension Plan are primarily based on years of service and final average earnings. During the year ended December 31, 2015, the Society of Actuaries issued a new mortality improvement scale (MP-2015), which we incorporated into the estimates of our defined benefit plan obligations as of December 31, 2015. During the year ended December 31, 2014, the Society of Actuaries issued new mortality tables (RP-2014) and a mortality improvement scale (MP-2014), which we incorporated into the estimates of our defined benefit plan obligations as of December 31, 2014. These changes to our mortality assumptions decreased and increased our projected benefit obligations as of December 31, 2015 and 2014 by approximately $25 million and $87 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, 2015 and 2014:

	December 31,	
	2015	2014
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations[1]		
Beginning obligations	$ (1,559)	$ (1,303)
Service cost	(3)	(3)
Interest cost	(64)	(66)
Actuarial gain(loss)	96	(268)
Benefits paid/employer contributions	75	81
Ending obligations	(1,455)	(1,559)
Fair value of plans assets		
Beginning obligations	898	886
Gain (loss) on plan assets	(36)	70
Employer contribution	8	3
Benefits paid	(55)	(61)
Ending plan assets	815	898
Funded status of plans	$ (640)	$ (661)
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (45)	$ (28)
Other long-term liability	(595)	(633)
Accumulated other comprehensive loss	261	276
	$ (379)	$ (385)

SERP Assumptions:		
Discount rate	4.75 %	4.25 %
Compensation increase rate	3.00 %	3.00 %
Measurement date	December 31, 2015	December 31, 2014
DMC Pension Plan Assumptions:		
Discount rate	4.67 %	4.16
Compensation increase rate	Frozen	Frozen
Measurement date	December 31, 2015	December 31, 2014

(1) The accumulated benefit obligation at December 31, 2015 and 2014 was approximately $1.443 billion and $1.544 billion, respectively.

Table of Contents

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

	Years Ended December 31,		
	2015	2014	2013
Service costs	$ 3	$ 3	$ 2
Interest costs	64	66	25
Expected return on plan assets	(57)	(60)	(15)
Amortization of net actuarial loss	12	4	7
Net periodic benefit cost	$ 22	$ 13	$ 19
SERP Assumptions:			
Discount rate	4.25 %	5.00 %	4.00 %
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, 2015	January 1, 2014	January 1, 2013
Census date	January 1, 2015	January 1, 2014	January 1, 2013
DMC Pension Plan Assumptions:			
Discount rate	4.16 %	5.18 %	5.01 %
Long-term rate of return on assets	6.50 %	7.00 %	7.00 %
Compensation increase rate	Frozen	Frozen	Frozen
Measurement date	January 1, 2015	January 1, 2014	October 1, 2013
Census date	January 1, 2015	January 1, 2014	January 1, 2013

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

We recorded gain/(loss) adjustments of $15 million, ($254) million and $69 million in other comprehensive income (loss) in the years ended December 31, 2015, 2014 and 2013, 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 $3 million, ($258) million and $62 million during the years ended December 31, 2015, 2014 and 2013, respectively, and the amortization of net actuarial loss of $12 million, $4 million and $7 million for the years ended December 31, 2015, 2014 and 2013, respectively, were recognized in other comprehensive income (loss). Cumulative net actuarial losses of $261 million, $276 million and $22 million as of December 31, 2015, 2014 and 2013, respectively, and unrecognized prior service costs of less than $1 million as of each of the years ended December 31, 2015, 2014 and 2013, have not yet been recognized as components of net periodic benefit costs.

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, 2015, were as follows:

Asset Category	Target	Actual
Cash and cash equivalents	6 %	5 %
United States government obligations	1 %	1 %
Equity securities	50 %	50 %
Debt Securities	43 %	44 %

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

Table of Contents

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 to monitor and react 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 a 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, 2015, aggregated by the level in the fair value hierarchy within which those measurements are determined. Fair value methodologies for Level 1, Level 2 and Level 3 are consistent with the inputs described in Note 19.

	December 31, 2015	(Level 1)	(Level 2)	(Level 3)
Cash and cash equivalents	$ 44	$ 44	$ —	$ —
United States government obligations	5	5	—	—
Corporate bonds	354	354	—	—
Equity securities	412	412	—	—
	$ 815	$ 815	$ —	$ —

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, 2015					Five Years
Total	2016	2017	2018	2019.	2020	Thereafter

Estimated benefit payments	$ 919	$ 82	$ 85	$ 88	$ 91	$ 93	$ 480

The SERP and DMC Pension Plan obligations of $640 million at December 31, 2015 are classified in the accompanying Consolidated Balance Sheet as an other current liability ($45 million) and defined benefit plan obligations ($595 million) based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately $45 million for the year ending December 31, 2016.

NOTE 9. CAPITAL COMMITMENTS

In connection with Vanguard's acquisition of Detroit Medical Center, certain capital commitments were agreed to be satisfied at particular dates. If these commitments are not met by these required dates, we are required to escrow cash for the purpose of funding certain capital projects. There was no required escrow balance as of December 31, 2015.

Table of Contents

NOTE 10. PROPERTY AND EQUIPMENT

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

	December 31,	
	2015	2014
Land	$ 680	$ 650
Buildings and improvements	7,041	7,013
Construction in progress	191	161
Equipment	4,326	4,387
	12,238	12,211
Accumulated depreciation and amortization	(4,323)	(4,478)
Net property and equipment	**$ 7,915**	**$ 7,733**

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 December 31, 2015 and 2014:

	2015	2014
Hospital Operations and other		
As of January 1:		
Goodwill	$ 5,642	$ 5,547
Accumulated impairment losses	(2,430)	(2,430)
Total	3,212	3,117
Goodwill acquired during the year and purchase price allocation adjustments	100	95
Goodwill allocated to assets held for sale	(190)	—
Impairment of goodwill	—	—
Total	**$ 3,122**	**$ 3,212**
As of December 31:		
Goodwill	$ 5,552	$ 5,642
Accumulated impairment losses	(2,430)	(2,430)

Total	**$ 3,122**	**$ 3,212**
Ambulatory Care		
As of January 1:		
Goodwill	$ 95	$ 37
Accumulated impairment losses	—	—
Total	95	37
Goodwill acquired during the year and purchase price allocation adjustments	3,148	58
Total	**$ 3,243**	**$ 95**
As of December 31:		
Goodwill	$ 3,243	$ 95
Accumulated impairment losses	—	—
Total	**$ 3,243**	**$ 95**

Table of Contents

	2015	2014
Conifer		
As of January 1:		
Goodwill	$ 606	$ 412
Accumulated impairment losses	—	—
Total	606	412
Goodwill acquired during the year and purchase price allocation adjustments	(1)	194
Total	**$ 605**	**$ 606**
As of December 31:		
Goodwill	$ 605	$ 606
Accumulated impairment losses	—	—
Total	**$ 605**	**$ 606**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of December 31, 2015 and 2014:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2015:			
Capitalized software costs	$ 1,456	$ (594)	$ 862
Trade names	106	—	106
Contracts	653	(26)	627
Other	119	(39)	80
Total	**$ 2,334**	**$ (659)**	**$ 1,675**
At December 31, 2014:			
Capitalized software costs	$ 1,412	$ (586)	$ 826
Trade Names	106	—	106
Contracts	57	(6)	51
Other	143	(38)	105
Total	**$ 1,718**	**$ (630)**	**$ 1,088**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2015 is as follows:

	Total	Years Ending December 31, 2016	2017	2018	2019	2020	Later Years
Amortization of intangible assets	$1,212	$ 189	$ 163	$ 136	$ 116	$ 88	$ 520

Table of Contents

NOTE 12. INVESTMENTS AND OTHER ASSETS

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

	December 31, 2015	2014
Marketable debt securities	$ 59	$ 77
Equity investments in unconsolidated healthcare entities	817	56
Total investments	876	133
Cash surrender value of life insurance policies	28	27
Long-term deposits	36	36
Land held for expansion, long-term receivables and other assets	235	188
Investments and other assets	**$ 1,175**	**$ 384**

Our policy is to classify investments that may be needed for cash requirements as "available-for-sale." In doing so, the carrying values of the shares and 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. At both December 31, 2015 and 2014, there were approximately $1 million of accumulated unrealized loss on these investments.

NOTE 13. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

	December 31, 2015	2014
Adjustments for defined benefit plans	$ (169)	$ (182)
Foreign currency translation adjustments	5	—
Accumulated other comprehensive loss	**$ (164)**	**$ (182)**

The tax effect allocated to the adjustments for our defined benefit plans was less than $1 million for the year ended December 31, 2015 and $93 million for the year ended December 31, 2014.

NOTE 14. 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.

Professional and General Liability Insurance

At December 31, 2015 and 2014, the aggregate current and long-term professional and general liability reserves in our accompanying Consolidated Balance Sheets were approximately $755 million and $681 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 2.09%, 1.97% and 2.45% at December 31, 2015, 2014 and 2013, respectively.

Table of Contents

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 $283 million, $232 million and $112 million for the years ended December 31, 2015, 2014 and 2013, respectively.

NOTE 15. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

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. 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.

Governmental Reviews and Lawsuits

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. The following matters are pending.

- *Clinica de la Mama Qui Tam Action and Criminal Investigation*—As previously disclosed, we and four of our hospital subsidiaries are defendants in civil qui tam litigation (*United States of America, ex rel. Ralph D. Williams v. Health Management Associates, Inc., et al.*) that alleges that the contractual arrangements between each of Atlanta Medical Center, North Fulton Hospital, Spalding Regional Medical Center and Hilton Head Hospital and Hispanic Medical Management, Inc. ("HMM") violated the federal and state anti-kickback statutes and false claims acts. HMM owned and operated clinics that provided, among other things, prenatal care predominantly to uninsured patients. Beginning in 2000, the

hospital subsidiaries contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. Subsequently, the Georgia Attorney General's Office and the U.S. Attorney's Office intervened in the qui tam action.

If the plaintiff in the pending civil litigation were to prevail, the potential sanctions could include up to three times the reimbursement of relevant government program payments received by the four hospital subsidiaries for uninsured HMM patients treated at the hospitals, the assessment of civil penalties and potential exclusion from participation in federal healthcare programs.

Also as previously disclosed, the U.S. Department of Justice ("DOJ") is conducting a criminal investigation of us, certain of our subsidiaries and former employees with respect to the contractual arrangements between HMM and the four hospitals. We are cooperating in the investigation and have responded, and continue to respond, to document and other requests pursuant to subpoenas issued to us and the four subsidiaries. If we or our subsidiaries were determined in any potential criminal proceeding to have violated the federal anti-kickback statute, the sanctions would include fines, which could be significant, and mandatory exclusion from participation in federal healthcare programs. Additional information regarding

Table of Contents

the procedural history of the qui tam action and criminal investigation is contained in quarterly and annual reports we have previously filed with the SEC.

In January 2016, we commenced discussions with the DOJ and the State of Georgia regarding potential resolution of these matters. Management increased its aggregate reserve for these matters in the three months ended December 31, 2015 from $20 million to $238 million to reflect an offer we made on February 18, 2016 to resolve the criminal investigation and civil litigation. We expect that the DOJ will make a counterproposal, and there can be no assurance that the ongoing discussions to resolve these matters will be successful. The terms of a final resolution may require us to pay significant fines and penalties and give rise to other costs or adverse consequences that materially exceed the reserve we have established. Based on the ongoing uncertainties and potentially wide range of outcomes associated with any potential resolution, we cannot estimate the ultimate amount of potential loss or range of reasonably possible loss we may face.

In addition to the payment of a monetary penalty, the final terms of any resolution of these matters could include: (i) the execution by the Company of a Corporate Integrity Agreement or a non-prosecution agreement, which may provide for the appointment of a corporate monitor and ongoing compliance audits; (ii) a deferred prosecution agreement by an intermediate subsidiary of the Company; and (iii) a commitment that one or more of the hospital subsidiaries subject to the investigation and proceedings enter into a guilty plea. The non-monetary terms of any resolution could expose us to increased operating costs, reputational harm, administrative burdens, and diminished profits and revenues.

To the extent that either the civil or the criminal matter discussed above is determined adversely to our interests, such determination could have a material adverse effect on our business, financial condition, results of operations or cash flows.

The following previously reported matters have recently been resolved.

- *Implantable Cardioverter Defibrillators ("ICDs")*—Fifty-six of our hospitals were subject to a DOJ review that was commenced in March 2010 to determine whether ICD procedures performed at the hospitals from 2002 to 2010 complied with Medicare coverage requirements. In July 2015, we reached final agreement with the DOJ to resolve the

investigation for approximately $12 million, which was fully reserved as of June 30, 2015 and paid on August 3, 2015.

- *Review of Conifer's Debt Collection Activities*—In order to resolve allegations that it had not fully complied in limited instances with debt validation and dispute resolution requirements under federal consumer protection laws, in June 2015, a Conifer subsidiary paid a civil penalty of less than $1 million and stipulated to a Consent Order issued by the U.S. Consumer Financial Protection Bureau ("CFPB"). The Consent Order requires the Conifer subsidiary to: (i) improve its consumer protection compliance program; (ii) make periodic reports to the CFPB over five years; (iii) forgive approximately $1 million in consumer debt; and (iv) pay approximately $5 million in consumer redress.

Antitrust Class Action Lawsuits Filed by Registered Nurses in Detroit and San Antonio

On January 27, 2016, the court granted final approval of a settlement between the parties in *Cason-Merenda, et al. v. VHS of Michigan, Inc. d/b/a Detroit Medical Center, et al.*, which was filed in December 2006 in the U.S. District Court for the Eastern District of Michigan. In that matter, a certified class composed of the registered nurses (exclusive of supervisory, managerial and advanced practical nurses) employed by eight unaffiliated Detroit-area hospital systems allege those hospital systems, including Detroit Medical Center ("DMC"), violated Section §1 of the federal Sherman Act by exchanging compensation-related information among themselves in a manner that reduced competition and suppressed the wages paid to such nurses. A subsidiary of Vanguard acquired DMC in January 2011, and we acquired Vanguard in October 2013. All of the defendant hospital systems other than DMC settled prior to our acquisition of Vanguard. We will make the $42 million settlement payment, which was fully reserved in the year ended December 31, 2015, by February 26, 2016.

Table of Contents

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 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. The case had been stayed since 2008; however, in July 2015, the court lifted the stay and re-opened discovery. Because these proceedings are at an early stage, it is impossible at this time to predict their outcome with any certainty; however, we believe that the ultimate resolution of this matter will not have a material effect on our business, financial condition or results of operations. We will continue to seek to defeat class certification and vigorously defend ourselves against the plaintiffs' allegations.

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.

In addition, as previously reported, in the year ended December 31, 2015, we paid a total of approximately $14 million to settle a class action lawsuit filed in Louisiana in March 1997 alleging tortious invasion of privacy as a result of the potential disclosure of patient identifying records. We had made an initial deposit of approximately $6 million into an escrow account in late November 2014 and,

based on low class participation as of March 31, 2015 (the end of the claims period), management reduced the reserve for this matter from approximately $12 million at December 31, 2014 to $8 million, recorded in discontinued operations, to reflect its then-current estimate of probable remaining liability. The case is now closed.

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 during the years ended December 31, 2015, 2014 and 2013:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2015					
Continuing operations	$ 73	$ 291	$ (72)	$ 7	$ 299
Discontinued operations	10	(8)	(2)	—	—
	$ 83	**$ 283**	**$ (74)**	**$ 7**	**$ 299**
Year Ended December 31, 2014					
Continuing operations	$ 64	$ 25	$ (16)	$ —	$ 73
Discontinued operations	6	18	(14)	—	10
	$ 70	**$ 43**	**$ (30)**	**$ —**	**$ 83**
Year Ended December 31, 2013					
Continuing operations	$ 5	$ 31	$ (10)	$ 38	$ 64
Discontinued operations	5	2	(1)	—	6
	$ 10	**$ 33**	**$ (11)**	**$ 38**	**$ 70**

Table of Contents

For the years ended December 31, 2015, 2014 and 2013, we recorded net costs of $283 million, $43 million and $33 million, respectively, in connection with significant legal proceedings and governmental reviews. The amount for 2013 in the column entitled "Other" above relates to reserves assumed as part of our acquisition of Vanguard in October 2013.

NOTE 16. REDEEMABLE NONCONTROLLING INTEREST IN EQUITY OF CONSOLIDATED SUBSIDIARIES

In October 2015, we formed a new joint venture with Baptist Health System, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership interest in the joint venture, and we manage the network's operations. Baptist Health System contributed four hospitals—Citizens Baptist Medical Center, Princeton Baptist Medical Center, Shelby Baptist Medical Center and Walker Baptist Medical Center—to the joint venture, and we contributed Brookwood Medical Center. The network also includes each contributed hospital's related businesses. We paid approximately $184 million to align the respective valuations of the assets contributed to the joint venture. The joint venture's operating agreement includes a put option that the minority owners may exercise on their respective non-controlling interest upon the occurrence of certain specified events. The redemption value is calculated using a fair market value analysis. As a result of this transaction, we recorded approximately $322 million of redeemable noncontrolling interests.

In August 2015, we formed a joint venture with Dignity Health and Ascension Health to own and operate Carondelet Health Network (the "Carondelet JV") based in Tucson, Arizona. We own a 60% controlling interest in the new joint venture and manage the operations of the network. Affiliates of Dignity Health and Ascension Health (the "minority owners") own the remaining 40% non-controlling interest in the Carondelet JV. The joint venture's operating agreement includes a put option that the minority owners may exercise on their respective non-controlling interest on September 1, 2025. The redemption value is calculated using a fair market value analysis. As a result of this transaction, we recorded approximately $68 million of redeemable noncontrolling interests.

In June 2015, we formed a new joint venture by combining our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI. We currently own 50.1% of the USPI joint venture. In connection with the formation of the USPI joint venture, we entered into a stockholders agreement pursuant to which we and our joint venture partners agreed to certain rights and obligations with respect to the governance of the joint venture.

As part of the USPI transaction, we also entered into a put/call agreement (the "Put/Call Agreement") that contains put and call options with respect to the equity interests in the joint venture held by our joint venture partners. Each year starting in 2016, our joint venture partners must put to us at least 12.5%, and may put up to 25%, of the equity held by them in the joint venture immediately after the closing. In each year that our joint venture partners are to deliver a put and do not put the full 25% of the USPI joint venture's shares allowable, we may call the difference between the number of shares our joint venture partners put and the maximum number of shares they could have put that year. In addition, the Put/Call Agreement contains certain other call options pursuant to which we will have the ability to acquire all of the ownership interests from our joint venture partners controlled by Welsh, Carson, Anderson & Stowe ("Welsh Carson") by 2020. In the event of a put by our joint venture partners controlled by Welsh Carson, we will have the ability to choose whether to settle the purchase price in cash or shares of our common stock and, in the event of a call by us, our joint venture partners controlled by Welsh Carson will have the ability to choose whether to settle the purchase price in cash or shares of our common stock.

In addition, we entered into a separate put call agreement (the "Baylor Put/Call Agreement") with Baylor University Medical Center that contains put and call options with respect to the equity interests in the USPI joint venture held by Baylor University Medical Center ("Baylor"). Each year starting in 2021, Baylor may put up to 1/3 of their total shares held as of January 1, 2017 in the joint venture. In each year that Baylor does not put the full 33.3% of the USPI joint venture's shares allowable, we may call the difference between the number of shares Baylor put and the maximum number of shares they could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of Baylor's ownership interest by 2024. We have the ability to choose whether to settle the purchase price for the Baylor put/call in cash or shares of our common stock.

Table of Contents

Based on the nature of these put/call structures, the minority shareholders' interests in the USPI joint venture is classified as redeemable noncontrolling interests in our Consolidated Balance Sheet at December 31, 2015. As a result of this transaction, we recorded approximately $1.48 billion of redeemable noncontrolling interests. In January 2016, Welsh Carson subsidiaries delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to the Put/Call Agreement. The estimated amount we will pay to repurchase these shares is $127 million.

When we acquired Vanguard Health Systems, Inc. ("Vanguard") in October 2013, we obtained a 51% controlling interest in a limited liability company that held the assets and liabilities of Valley Baptist Health System ("Valley Baptist"), which consists of two hospitals in Brownsville and Harlingen, Texas. The remaining 49% noncontrolling interest in the joint venture was held by the former owner of Valley Baptist (the "seller"). The joint venture operating agreement included a put option that would

allow the seller to require us to purchase all or a portion of the seller's remaining noncontrolling interest in the limited liability company at certain specified time periods. In connection with the seller's exercise and the settlement of the put option, we acquired the remaining 49% noncontrolling interest from the seller on February 11, 2015 in exchange for approximately $254 million in cash, which was applied to and reduced our redeemable noncontrolling interests, with the difference between the payment and the carrying value of approximately $270 million recorded as additional paid-in capital. The redemption value of the put option was calculated pursuant to the terms of the operating agreement based on the operating results and the debt of the joint venture. As a result, we now own 100% of Valley Baptist.

In January 2015, Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. At that time, CHI increased its minority ownership position in Conifer's revenue cycle solutions subsidiary, Conifer Health Solutions, LLC, to approximately 23.8%, resulting in an increase in our redeemable noncontrolling interests of approximately $47 million.

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the years ended December 31, 2015 and 2014:

	Years Ended December 31,	
	2015	2014
Balances at beginning of period	**$ 401**	**$ 340**
Net income	166	33
Distributions paid to noncontrolling interests	(60)	(8)
Contributions from noncontrolling interests	1	11
Purchases and sales of businesses and noncontrolling interests, net	1,758	25
Balances at end of period	**$ 2,266**	**$ 401**

NOTE 17. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2015, 2014 and 2013 consists of the following:

	Years Ended December 31,		
	2015	2014	2013
Current tax expense (benefit):			
Federal	$ (2)	$ (12)	$ 2
State	28	18	4
	26	6	6
Deferred tax expense (benefit):			
Federal	24	46	(56)
State	18	(3)	(15)
	42	43	(71)
	$ 68	**$ 49**	**$ (65)**

Table of Contents

A reconciliation between the amount of reported income tax expense (benefit) 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 for the year ended December 31, 2015 includes $11 million of expense related to the write off of expired unutilized state net operating loss carryforwards for which a full valuation allowance had been provided in prior years. A corresponding

tax benefit of $11 million is included for the year ended December 31, 2015 to reflect the reduction in the valuation allowance.

	Years Ended December 31,		
	2015	2014	2013
Tax expense at statutory federal rate of 35%	$ 50	$ 52	$ (55)
State income taxes, net of federal income tax benefit	18	5	1
Expired state net operating losses, net of federal income tax benefit	11	34	—
Tax attributable to noncontrolling interests	(59)	(23)	(10)
Nondeductible goodwill	22	—	—
Nontaxable gains	(11)	—	—
Nondeductible litigation	44	—	—
Nondeductible acquisition costs	4	2	6
Nondeductible health insurance provider fee	2	3	—
Changes in valuation allowance	4	(20)	(2)
Change in tax contingency reserves, including interest	7	(2)	(7)
Amendment of prior-year tax returns	(17)	—	—
Prior-year provision to return adjustments and other changes in deferred taxes	(12)	(5)	3
Other items	5	3	(1)
	$ 68	$ 49	$ (65)

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, 2015		December 31, 2014	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ —	$ 718	$ —	$ 847
Reserves related to discontinued operations and restructuring charges	15	—	28	—
Receivables (doubtful accounts and adjustments)	185	—	173	—
Deferred gain on debt exchanges	—	32	—	42
Accruals for retained insurance risks	318	—	329	—
Intangible assets	—	366	—	157
Other long-term liabilities	141	—	166	—
Benefit plans	459	—	451	—
Other accrued liabilities	99	—	83	—
Investments and other assets	—	69	—	4
Net operating loss carryforwards	715	—	659	—
Stock-based compensation	40	—	31	—
Other items	55	6	80	—
	2,027	1,191	2,000	1,050
Valuation allowance	(96)	—	(87)	—
	$1,931	$ 1,191	$1,913	$ 1,050

Table of Contents

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

	December 31,	
	2015	2014
Deferred income tax assets	$ 776	$ 863
Other long-term liabilities	(36)	—
Net deferred tax asset	**$ 740**	**$ 863**

During the year ended December 31, 2015, the valuation allowance increased by $9 million, $5 million due to the acquisition of USPI and $4 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2015 is $96 million. During the year ended December 31, 2014, the valuation allowance decreased by $20 million, primarily due to the expiration of unutilized state net operating loss carryovers. During the year ended December 31, 2013, the valuation allowance increased by $51 million, $34 million due to the acquisition of Vanguard and $17 million primarily due to the adjustment of deferred tax assets for state net operating loss carryforwards that have a full valuation allowance.

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 table below summarizes the total changes in unrecognized tax benefits during the year ended December 31, 2015. 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, 2015, 2014 and 2013.

	Continuing Operations	Discontinued Operations	Total
Balance at December 31, 2012	**31**	**1**	**32**
Additions for prior-year tax positions	15	—	15
Additions for current-year tax positions	3	—	3
Reductions due to a lapse of statute of limitations	(6)	(1)	(7)
Balance at December 31, 2013	**43**	**$ —**	**43**
Reductions for tax positions of prior years	(1)	—	(1)
Additions for current-year tax positions	1	—	1
Reductions due to a lapse of statute of limitations	(5)	—	(5)
Balance at December 31, 2014	**$ 38**	**$ —**	**$ 38**
Additions for prior-year tax positions	1	—	1
Additions for current-year tax positions	5	—	5
Reductions due to a lapse of statute of limitations	(4)	—	(4)
Balance at December 31, 2015	**$ 40**	**$ —**	**$ 40**

The total amount of unrecognized tax benefits as of December 31, 2015 was $40 million, of which $37 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, 2015 includes expense of $2 million in continuing operations attributable to a increase in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2014 was $38 million, of which $31 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, 2014 includes a benefit of $6 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, 2013 was $43 million, of which $34 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2013 includes a benefit of $1 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects.

Our practice is to recognize interest and/or penalties related to income tax matters in income tax expense in our consolidated statements of operations. Approximately $3 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, 2015. Total accrued interest and penalties on unrecognized tax benefits as of December 31, 2015 were $6 million, all of which related to continuing operations.

The Internal Revenue Service ("IRS") has completed audits of our tax returns for all tax years ending on or before December 31, 2007, and of Vanguard's tax returns for fiscal years ending on or before June 30, 2004. 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 Vanguard's tax returns for fiscal years ended after June 30, 2004 remain subject to examination by the IRS. Vanguard's tax returns for fiscal years ended June 30, 2013 and October 1, 2013 are currently under audit by the IRS. USPI tax returns for years ended after December 31, 2011 remain subject to audit.

As of December 31, 2015, approximately $7 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, 2015, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.8 billion pretax expiring in 2024 to 2034, (2) approximately $28 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $22 million expiring in 2023 through 2035, and (4) state NOL carryforwards of $3.1 billion expiring in 2014 through 2035 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $12 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 (see Note 2), 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.

Table of Contents

NOTE 18. EARNINGS (LOSS) PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for income (loss) from continuing operations for the years ended December 31, 2015, 2014 and 2013. Income (loss) 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, 2015			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (142)	99,167	$ (1.43)
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	**$ (142)**	**99,167**	**$ (1.43)**
Year Ended December 31, 2014			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 34	97,801	$ 0.35
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,486	(0.01)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 34**	**100,287**	**$ 0.34**
Year Ended December 31, 2013			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (123)	101,648	$ (1.21)
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	**$ (123)**	**101,648**	**$ (1.21)**

All potentially dilutive securities were excluded from the calculation of diluted earnings (loss) per share for the years ended December 31, 2015 and 2013, because we did not report income from continuing operations in the period. In circumstances where we do not have income from continuing operations, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations in those periods, 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 2,380 and 2,310 for the years ended December 31, 2015 and 2013, respectively.

NOTE 19. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of December 31, 2015 and 2014. The following tables also 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. 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, interest rates and yield

Table of Contents

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.

Investments	December 31, 2015	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 59	$ 24	$ 35	$ —
	$ 59	**$ 24**	**$ 35**	**$ —**

Quoted Prices

Investments	December 31, 2014	in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable securities — current	$ 2	$ 2	$ —	$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
Marketable debt securities — noncurrent	60	54	5	1
	$ 64	$ 56	$ 7	$ 1

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 table presents this information and indicates 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.

	December 31, 2015	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 and used	$ 45	$ —	$ 45	$ —

	December 31, 2014	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 and used	$ 23	$ —	$ 23	$ —

As described in Note 5, in the year ended December 31, 2015, we recorded impairment charges in continuing operations of $19 million for the write-down of buildings, equipment and other long-lived assets of two hospitals to their estimated fair values. In the year ended December 31, 2014, we recorded an impairment charge in continuing operations of $20 million for the write-down of buildings, equipment and other long-lived assets of one hospital to their estimated fair values primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment.

The fair value of our long-term debt 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

Table of Contents

December 31, 2015 and 2014, the estimated fair value of our long-term debt was approximately 96.2% and 105.0%, respectively, of the carrying value of the debt.

NOTE 20. ACQUISITIONS

During the year ended December 31, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets into a new joint venture. We also completed the acquisition of Aspen, a network of nine private hospitals and clinics in the United Kingdom. In addition, we began operating Hi-Desert Medical Center, which is a 59-bed acute care hospital in Joshua Tree, California, and its related healthcare facilities, including a 120-bed skilled nursing facility, an ambulatory surgery center and an imaging center, under a long-term lease agreement. Furthermore, we formed a new joint venture with Dignity Health and Ascension Health to own and operate Carondelet Health Network, which is comprised of three hospitals with over 900 licensed beds, related physician practices, ambulatory surgery, imaging and urgent care centers, and other affiliated businesses, in Tucson and Nogales, Arizona. We also formed a new joint venture with Baptist Health Systems, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership in the joint venture, and manage the network's operations. The network has more than 1,700 licensed beds, nine outpatient centers, 68 physician clinics, delivering primarily and specialty care, and more than 7,000 employees and approximately 1,500 affiliated physicians. Additionally, we acquired majority interests in nine ambulatory surgery centers and purchased 35 urgent care centers (all of which are owned by our USPI joint venture), and various physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $940 million.

During the year ended December 31, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. We also acquired five ambulatory surgery centers, three urgent care centers, one diagnostic imaging center, SPi Healthcare, a provider of revenue cycle management, health information management and software solutions, and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $428 million.

During the year ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $1.515 billion.

We are required to allocate the purchase prices of the acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values at the respective acquisition dates. The excess of the purchase price allocated over those fair values is recorded as goodwill. The purchase price allocations for certain acquisitions completed in 2015, including our USPI joint venture, is preliminary. We are in the process of obtaining and evaluating valuations of the acquired property and equipment, management contracts and other intangible assets, equity method investments and noncontrolling interests. Therefore, those purchase price allocations including goodwill recorded in these consolidated financial statements are subject to adjustment once the valuation work is completed and evaluated. Such adjustments will be recorded as soon as practical and within the measurement period as defined by the accounting literature. During the year ended December 31, 2014, we completed the analysis required to finalize the purchase price allocation for our acquisition of Vanguard. During the years ended December 31, 2015, 2014 and 2013, we made adjustments to purchase price allocations for businesses acquired in 2014, 2013 and 2012 (other than Vanguard), respectively, that increased (decreased) goodwill by approximately ($11) million, $7 million and $5 million, respectively.

Preliminary or final purchase price allocations for all the acquisitions made during the years ended December 31, 2015, 2014 and 2013 are as follows:

	2015	2014	2013
Current assets	$ 457	$ 34	$ 980
Property and equipment	1,059	113	2,890
Other intangible assets	361	46	213
Goodwill	3,374	340	2,645
Other long-term assets	557	2	160
Current liabilities	(443)	(30)	(1,205)
Deferred taxes — long term	(128)	(18)	(116)
Other long-term liabilities	(2,146)	(23)	(3,725)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(1,974)	(21)	(268)
Noncontrolling interests	(147)	(15)	(49)
Cash paid, net of cash acquired	**$ 940**	**$ 428**	**$ 1,515**
Gains on consolidations	**$ 30**	**$ —**	**$ 10**

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 increased reimbursement. Approximately $45 million, $16 million and $6 million in transaction costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2015, 2014 and 2013, 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, 2015 and 2013, we recognized gains totaling $30 million and $10 million, respectively, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

USPI Joint Venture and Acquisition of Aspen

Effective June 16, 2015, we entered into the USPI joint venture, of which we own 50.1%. On the date of acquisition, the joint venture had interests in 249 ambulatory surgery centers, 18 short-stay surgical hospitals and 20 imaging centers in 29 states. We refinanced approximately $1.5 billion of existing USPI debt, which was allocated to the joint venture through an intercompany loan, and paid approximately $424 million in cash to align the respective valuations of the assets contributed to the joint venture. We also completed the Aspen acquisition for approximately $226 million.

The preliminary purchase price allocations for our USPI joint venture and Aspen acquisition, which are also included in the table above, are as follows:

Current assets	$ 237
Property and equipment	526
Other intangible assets	359
Goodwill	2,786
Other long-term assets	658
Current liabilities	(306)
Deferred taxes — long term	(128)
Other long-term liabilities	(2,025)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(1,477)
Noncontrolling interests	(64)
Cash paid, net of cash acquired	**$ 566**

Pro Forma Information – Unaudited

The following table provides certain pro forma information for Tenet as if the USPI joint venture and Aspen acquisition had occurred at the beginning of the year ended December 31, 2013. The net income of USPI for the year ended December 31, 2015 was adjusted by $30 million to remove a nonrecurring loss on extinguishment of debt.

	Years Ended December 31,		
	2015	2014	2013
Net operating revenues	$ 19,018	$ 17,423	$ 11,851
Equity in earnings of unconsolidated affiliates	$ 143	$ 129	$ 111
Net loss attributable to common shareholders	$ (171)	$ (40)	$ (156)
Net loss per share attributable to common shareholders	$ (1.73)	$ (0.41)	$ (1.53)

NOTE 21. SEGMENT INFORMATION

In the three months ended June 30, 2015, we began reporting Ambulatory Care as a separate reportable business segment. Previously, our business consisted of our Hospital Operations and other segment and our Conifer segment. Effective June 16, 2015, we completed the joint venture transaction that combined our freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets. We contributed our interests in 49 ambulatory surgery centers and 20 imaging centers, which had previously been included in our Hospital Operations and other segment, to the USPI joint venture. The USPI joint venture has interests in 249 ambulatory surgery centers, 20 short-stay surgical hospitals, 20 imaging centers and 35 urgent care centers in 28 states. We also completed the acquisition of Aspen effective June 16, 2015, which includes nine private hospitals and clinics in the United Kingdom. Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and Aspen facilities. 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 core business is Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, urgent care centers, freestanding emergency departments, physician practices and health plans. We also own various related healthcare businesses. At December 31, 2015, our subsidiaries operated 86 hospitals, with a total of 22,525 licensed beds, primarily serving urban and suburban communities in 14 states, and six health plans, as well as hospital-based outpatient centers, freestanding emergency departments and freestanding urgent care centers.

We provide healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans, under our Conifer subsidiary. At December 31, 2015, Conifer provided services to more than 800 Tenet and non-Tenet hospitals and other clients nationwide. Our Conifer subsidiary and our Hospital Operations and other segment entered into formal agreements documenting terms and conditions of various services provided by Conifer to Tenet hospitals, as well as certain administrative services provided by our Hospital Operations and other segment to Conifer. The services provided by both parties under these agreements are charged to the other party based on estimated third-party pricing terms.

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,	
	2015	2014
Assets:		
Hospital Operations and other	$17,353	$16,810
Ambulatory Care	5,159	212
Conifer	1,170	929
Total	**$23,682**	**$17,951**

Table of Contents

	Years Ended December 31,		
	2015	2014	2013
Capital expenditures:			
Hospital Operations and other	$ 786	$ 899	$ 664
Ambulatory Care	28	9	6
Conifer	28	25	21
Total	**$ 842**	**$ 933**	**$ 691**
Net Operating revenues:			
Hospital Operations and other	$16,928	$15,681	$10,367
Ambulatory Care	959	320	205
Conifer			
Tenet	666	591	404
Other customers	747	602	515
Total Conifer revenues	1,413	1,193	919
Intercompany eliminations	(666)	(591)	(404)
Total	**$18,634**	**$16,603**	**$11,087**
Adjusted EBITDA:			
Hospital Operations and other	$ 1,653	$ 1,651	$ 1,146
Ambulatory Care	358	98	64
Conifer	265	203	132
Total	**$ 2,276**	**$ 1,952**	**$ 1,342**
Depreciation and amortization:			
Hospital Operations and other	$ 702	$ 810	$ 516
Ambulatory Care	46	14	10
Conifer	49	25	19
Total	**$ 797**	**$ 849**	**$ 545**
Adjusted EBITDA	**$ 2,276**	**$ 1,952**	**$ 1,342**
Depreciation and amortization	(797)	(849)	(545)
Impairment and restructuring charges, and acquisition-related costs	(318)	(153)	(103)
Litigation and investigation costs	(291)	(25)	(31)
Interest expense	(912)	(754)	(474)
Loss from early extinguishment of debt	(1)	(24)	(348)
Gains on sales, consolidation and deconsolidation of facilities	186	—	—
Investment earnings	1	—	1
Net income (loss) from continuing operations before income taxes	**$ 144**	**$ 147**	**$ (158)**

NOTE 22. RECENT ACCOUNTING STANDARDS

Recently Adopted Accounting Standards

In April 2015, the Financial Accounting Standards Board ("FASB") issued ASU 2015-03, "Interest–Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs," which requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability. As further discussed in Note 1, we adopted ASU 2015-03 effective December 31, 2015 and such adoption did not affect the Company's results of operations or cash flows.

In November 2015, the FASB issued ASU 2015-17, "Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes," which requires that deferred tax liabilities and assets be classified as noncurrent in a classified balance sheet. As further discussed in Note 1, we adopted ASU 2015-17

effective December 31, 2015 and such adoption did not affect the Company's results of operations or cash flows.

Table of Contents

Recently Issued Accounting Standards

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. 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. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2018.

Table of Contents

SUPPLEMENTAL FINANCIAL INFORMATION

SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)

	Year Ended December 31, 2015			
	First	Second	Third	Fourth
Net operating revenues	$ 4,424	$ 4,492	$ 4,692	$ 5,026
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ 47	$ (61)	$ (29)	$ (97)
Net income (loss)	$ 76	$ (28)	$ 28	$ 2
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic	$ 0.48	$ (0.61)	$ (0.29)	$ (0.98)
Diluted	$ 0.47	$ (0.61)	$ (0.29)	$ (0.98)

	Year Ended December 31, 2014			
	First	Second	Third	Fourth
Net operating revenues	$ 3,925	$ 4,038	$ 4,175	$ 4,465
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (32)	$ (26)	$ 9	$ 61
Net income (loss)	$ (16)	$ (7)	$ 18	$ 81
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				

Basic	$ (0.33)	$ (0.27)	$ 0.09	$ 0.62
Diluted	$ (0.33)	$ (0.27)	$ 0.09	$ 0.61

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

Table of Contents

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

We formed our USPI Holding Company, Inc. ("USPI joint venture") and acquired European Surgical Partners Ltd. ("Aspen") on June 16, 2015. The facilities acquired as part of these transactions utilize different information technology systems than our other facilities. We have excluded all of the USPI joint venture and Aspen operations from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. The rules of the Securities and Exchange Commission ("SEC") require us to include acquired entities in our assessment of the effectiveness of internal control over financial reporting no later than the annual management report following the first anniversary of the acquisition. We will complete the evaluation and integration of the USPI joint venture and Aspen operations within the required timeframe and report management's assessment of our internal control over financial reporting, including the acquired hospitals and other operations, in our first annual report in which such assessment is required. Other than the USPI joint venture and Aspen transactions, there were no changes in our internal control over financial reporting during the quarter ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report with respect to our operations that existed prior to the USPI joint venture and Aspen transactions. 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 106 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 107 herein.

ITEM 9B. OTHER INFORMATION

None.

Table of Contents

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, 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.

Table of Contents

PART IV.

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The Consolidated Financial Statements and notes thereto can be found on pages 109 through 156.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 168).

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

EXHIBITS

(2) Plan of Acquisition, Reorganization, Arrangement, Liquidation or Succession

(a) Contribution and Purchase Agreement, dated March 23, 2015, by and among the Registrant, USPI Group Holdings, Inc., Ulysses JV Holding I L.P., Ulysses JV Holding II L.P. and BB Blue Holdings, Inc. (Incorporated by reference to Exhibit 2.1 to Registrant's Current Report on Form 8-K, dated and filed March 23, 2015)

(b) Put/Call Agreement, dated June 16, 2015, by and among the Registrant, USPI Group Holdings, Inc., Ulysses JV Holding I L.P., Ulysses JV Holding II L.P. and USPI Holding Company, Inc. (Incorporated by reference to Exhibit 2(b) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, filed August 3, 2015)

(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 Designation, Preferences, and Rights of Series A Junior Participating Preferred Stock, par value $0.15 per share, dated January 7, 2011 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(c) 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, dated October 10, 2012 and filed October 11, 2012)

(d)

Amended and Restated Bylaws of the Registrant, as amended and restated effective January 7, 2011 (Incorporated by reference to Exhibit 3.2 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(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, dated November 6, 2001 and filed November 9, 2001)

Table of Contents

(b) Third Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee, relating to 6⅞% Senior Notes due 2031 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(c) Twelfth Supplemental Indenture, dated as of August 17, 2010, 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 8% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed August 17, 2010)

(d) Fourteenth Supplemental Indenture, dated as of November 21, 2011, 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 6¼% Senior Secured Notes due 2018 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated November 21, 2011 and filed November 22, 2011)

(e) 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 4¾% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(f) 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 6¾% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(g) 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 4½% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed February 5, 2013)

(h) 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 4⅞% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated May 30, 2013 and filed May 31, 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 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and 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 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(k) 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 8⅛% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

Table of Contents

(l) 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 8⅛% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(m) Twenty-Third Supplemental Indenture, dated as of March 10, 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% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated March 7, 2014 and filed March 10, 2014)

(n) 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 5½% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K dated and filed September 29, 2014)

(o) Twenty-Sixth Supplemental Indenture, dated as of June 16, 2015, 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 Floating Rate Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed June 16, 2015)

(p) Indenture, dated as of June 16, 2015, between THC Escrow Corporation II and The Bank of New York Mellon Trust Company, N.A. (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed June 16, 2015)

(q) Supplemental Indenture, dated as of June 16, 2015, between the Registrant and The Bank of New York Mellon Trust Company, N.A. (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated and filed June 16, 2015)

(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, dated October 19, 2010 and 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, dated November 29, 2011 and 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)

Table of Contents

(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, dated December 4, 2015 and 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, dated March 7, 2014 and filed March 10, 2014)

(f) 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, dated March 7, 2014 and filed March 10, 2014)

(g) 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, dated March 3, 2009 and filed March 5, 2009)

(h) 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†

(i) 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, dated June 15, 2009 and filed June 16, 2009)

(j) 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†

(k) 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†

(l) 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, dated March 3, 2009 and filed March 5, 2009)

(m) Support Agreement, dated January 18, 2016, by and among the Registrant, 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, L.P. (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated January 18, 2016 and filed January 19, 2016)

(n) Letter from the Registrant to Trevor Fetter, dated November 7, 2002 (Incorporated by reference to Exhibit 10(k) to Registrant's Transition Report on Form 10-K for the seven-month transition period ended December 31, 2002, filed May 15, 2003) *

Table of Contents

(o) Letter from the Registrant to Trevor Fetter dated September 15, 2003 (Incorporated by reference to Exhibit 10(l) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, filed November 10, 2003)*

(p) 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)*

(q) Letter from the Registrant to Britt T. Reynolds, dated December 15, 2011 (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2011, filed February 28, 2012)*

(r) Letter from the Registrant to Daniel J. Cancelmi, dated September 6, 2012 (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(s) 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)*

(t) Tenet Second Amended and Restated Executive Severance Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(e) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(u) Tenet Healthcare Corporation Ninth Amended and Restated Supplemental Executive Retirement Plan, as amended and restated effective November 30, 2015*†

(v) 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)*

(w) Fourth Amended and Restated Tenet 2006 Deferred Compensation Plan, as amended and restated effective November 30, 2015*†

(x) 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)*

(y) 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, dated February 14, 2006 and filed February 17, 2006)*

(z) Fifth Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan, as amended and restated effective February 26, 2014 (Incorporated by reference to Exhibit 4.1 to Registrant's Registration Statement on Form S-8, filed May 23, 2014)*

(aa) 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)*

Table of Contents

(bb) Award Agreement, dated June 13, 2013, used to evidence grant of performance-based restricted stock units to Trevor Fetter under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, filed August 6, 2013)*

(cc) Form of Award used to evidence grants of performance cash awards under the Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan and the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit (ee) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2009, filed February 23, 2010)*

(dd)

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)*

(ee) Second Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(k) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(ff) Sixth Amended and Restated Tenet Executive Retirement Account, as amended and restated effective November 30, 2015*†

(gg) 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) Consent of Deloitte & Touche LLP†

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

(a) Certification of Trevor Fetter, Chief Executive Officer and Chairman of the Board of Directors†

(b) Certification of Daniel J. Cancelmi, Chief Financial Officer†

(32) Section 1350 Certifications of Trevor Fetter, Chief Executive Officer and Chairman of the Board of Directors, and Daniel J. Cancelmi, Chief Financial Officer†

(101 INS)XBRL Instance Document

(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

---

* Management contract or compensatory plan or arrangement.
† Filed herewith.

Table of Contents

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 22, 2016 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 22, 2016 By: /s/ TREVOR FETTER
Trevor Fetter
Chief Executive Officer and Chairman
of the Board of Directors
(Principal Executive Officer)

Date: February 22, 2016 By: /s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer
(Principal Financial Officer)

Date: February 22, 2016 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Date: February 22, 2016 By: /s/ BRENDA J. GAINES
Brenda J. Gaines
Director

Date: February 22, 2016 By: /s/ KAREN M. GARRISON
Karen M. Garrison
Director

Date: February 22, 2016 By: /s/ EDWARD A. KANGAS
Edward A. Kangas
Lead Director

Date: February 22, 2016 By: /s/ J. ROBERT KERREY
J. Robert Kerrey
Director

Date: February 22, 2016 By: /s/ FREDA C. LEWIS-HALL, M.D.
Freda C. Lewis-Hall, M.D.
Director

Date: February 22, 2016 By: /s/ RICHARD R. PETTINGILL
Richard R. Pettingill
Director

Date: February 22, 2016 By: /s/ MATTHEW J. RIPPERGER
Matthew J. Ripperger
Director

Date: February 22, 2016 By: /s/ RONALD A. RITTENMEYER
Ronald A. Rittenmeyer
Director

Table of Contents

Date: February 22, 2016 By: /s/ TAMMY ROMO

Tammy Romo
Director

Date: February 22, 2016 By: /s/ RANDOLPH C. SIMPSON
Randolph C. Simpson
Director

Date: February 22, 2016 By: /s/ JAMES A. UNRUH
James A. Unruh
Director

Table of Contents

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Additions Charged To: Costs and Expenses[1] [2]	Additions Charged To: Other Accounts	Deductions [3]	Other Items [4]	Balance at End of Period
Allowance for doubtful accounts:						
Year ended December 31, 2015	$ 852	$ 1,480	$ —	$ (1,388)	$(57)	$ 887
Year ended December 31, 2014	$ 589	$ 1,305	$ —	$ (1,042)	$ —	$ 852
Year ended December 31, 2013	$ 401	$ 975	$ —	$ (787)	$ —	$ 589
Valuation allowance for deferred tax assets						
Year ended December 31, 2015	$ 87	$ 4	$ —	$ —	$ 5	$ 96
Year ended December 31, 2014	$ 107	$ (20)	$ —	$ —	$ —	$ 87
Year ended December 31, 2013	$ 56	$ 23	$ (1)	$ —	$ 29	$ 107

(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.

Attachment - Contribution to the Orderly Development Of Health Care - 4A

Current License
The Joint Commission Accreditation

Board for Licensing Health Care Facilities

State of Tennessee

0000000161

No. of Beds 0196

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SAINT FRANCIS HOSPITAL - BARTLETT, INC. *to conduct and maintain a*

Hospital SAINT FRANCIS HOSPITAL - BARTLETT

Located at 2986 KATE BOND ROAD, BARTLETT

County of SHELBY *, Tennessee.*

This license shall expire JUNE 02 *,* 2017 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 13TH *day of* MAY *,* 2016 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent T. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

The Joint Commission

June 24, 2016

Christopher Locke
CEO
Saint Francis Hospital - Bartlett
2986 Kate Bond Road
Bartlett, TN 38133

Joint Commission ID #: 394923
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 06/24/2016

Dear Mr. Locke:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospitals**

This accreditation cycle is effective beginning March 19, 2016 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

Saint Francis Hospital - Bartlett

Bartlett, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

March 19, 2016

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #394923
Print/Reprint Date: 06/27/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

CERTIFICATE OF DISTINCTION

has been awarded to

Saint Francis Hospital - Bartlett

Bartlett, TN

for Advanced Certification as a

Primary Stroke Center

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care.

June 7, 2016

Certification is customarily valid for up to 24 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #394923
Print/Reprint Date: 06/08/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Attachment - Contribution to the Orderly Development Of Health Care - 4A

Department of Health Letter

Attachment - Contribution to the Orderly Development Of Health Care

Proof of Publication

Police Report

MPD waiting on cause of death in body found

Memphis police said they are waiting on a ruling from the Shelby County Medical Examiner's office to determine the cause of death of a man found Friday night in Downtown Memphis.

Police responded around 9:30 p.m. to a "man down" call at the intersection of Florida and Carolina, outside Loflin Yard restaurant and several apartment complexes.

Officers located a male, who was pronounced dead on the scene, MPD said in an emailed statement Saturday.

The man's name and age have not been released by police, and the investigation continues, said police spokesman Louis Brownlee.

State briefs

Elusive high-speed internet sprouts in rural Tennessee

NASHVILLE - Rural Scott County could serve as a model for how grant money can be leveraged to spur much-needed infrastructure investments such as high-speed Internet.

The Tennessean reported that Scott County, 60 miles northwest of Knoxville, is classified by the state as economically distressed, but its local cooperative now has some of the fastest internet services in the nation.

Recent county upgrades that include 2,700 miles of fiber installation stem from a $67 million federal grant awarded to Highland Telephone Cooperative in 2010, part of the 2009 American Recovery and Reinvestment Act.

The benefits have been wide-ranging and have helped local businesses, schools and health care clinics.

Gov. Bill Haslam has created a group within his administration to study how to improve rural broadband access across the state.

Fort Campbell soldier from Texas dies in Jordan

FORT CAMPBELL, Ky. - The Department of Defense announced the death of Special Forces soldier who was serving in Jordan.

According to a statement from the DOD, Spc. Isiah L. Booker of Cibolo, Texas, died Jan. 7 in a noncombat-related incident. Booker was assigned to the 2nd Battalion, 5th Special Forces Group at Fort Campbell, a sprawling Army post on the Kentucky-Tennessee border.

The unit is part of Operation Inherent Resolve, the U.S. military's name for the campaign to drive Islamic State extremists out of Iraq and Syria.

The statement said the incident is under investigation. No further details were immediately available.

Shotgun blast kills 11-year-old on hunting trip

SPRINGFIELD - An 11-year-old boy was fatally shot during a hunting trip in northern Tennessee.

Adams Fire Chief Ray Brown said the boy was shot in the side by a 20-gauge shotgun.

Robertson County Emergency Management Services Assistant Director Russell Gupton said the boy was accidentally shot Sunday afternoon at the Three Feathers Hunting Preserve in Cedar Hill.

It is unclear how the shooting occurred or who was with the boy at the time. He was not immediately identified, and no charges were immediately filed.

Gupton said initial reports indicated he was 12, but records from Robertson EMS say the child was 11 and lived in Clarksville.

Three Feathers' website said the preserve specializes in private hunts for game birds.

State's highest court to hear arguments in Knoxville

KNOXVILLE - Tennessee's Supreme Court is heading to Knoxville to hear arguments in four cases.

A news release said court will be in session Tuesday in Knoxville.

One case will decide whether someone who won a judicial election but hasn't taken office yet acts as a state officer or employee in making administrative staffing provisions. The case also deals with whether a judicial administrative assistant is an at-will employee.

Another case deals with whether the Court of Criminal Appeals erred in finding that trial evidence wasn't sufficient to support a man's conviction for aggravated stalking.

A third case addresses trusts and arbitration. The final case deals with attorney discipline.

Tennessee Sandhill Crane Festival is set for the weekend

NASHVILLE - The annual Tennessee Sandhill Crane Festival is Saturday and Sunday at the Hiwassee Refuge and Birchwood Community Center.

The festival celebrates thousands of cranes that migrate through or winter around the Hiwassee Refuge.

The Tennessee Wildlife Resources Agency said the recovering population of eastern sandhill cranes began stopping at the refuge in the early 1990s on their way to and from wintering grounds in Georgia and Florida.

At the refuge, the cranes found the right combination of feeding and shallow water roosting habitat. Now as many as some 12,000 of the birds spend the winter at the confluence of the Hiwassee and Tennessee rivers.

The wildlife agency has managed the refuge for more than 60 years for waterfowl.

The festival site is about 35 miles northeast of Chattanooga.

No students injured as flames consume Alcoa school bus

ALCOA - No students were injured when a school bus burst into flames shortly after its driver noticed smoke and unloaded 29 children on board.

Alcoa City Schools Director Brian Bell said that at about 7 a.m. Monday, the driver heard a pop from the back of a bus carrying students from elementary through high school. He smelled and saw smoke, and pulled over.

Bell said the driver moved students away from the bus and called authorities. Students waited 17 minutes for another bus to pick them up.

By the time the fire department arrived around 20 to 30 minutes later, the bus was completely consumed in flames.

Bell said officials believe a brake overheated or locked up, began melting the tire and slowly started the fire.

The investigation is ongoing.

Police investigate death of child found shot at hotel

JACKSON - Investigators in Jackson are asking the public for information about an 11-year-old child who was found shot at a hotel and later died.

The Jackson Police Department said officers found a child with a gunshot wound at an Americas' Best Value Inn on Friday night. Police said the child, who was not identified, died at a hospital in Memphis on Saturday morning.

Police said preliminary findings show the shooting was accidental, but authorities are still investigating. An autopsy was being performed.

No more details have been released. Anyone with information about the case should contact Jackson police.

— *Associated Press*

Waters

Continued from Page 1B

ish and fulfill their God-given potential."

The letter originated with Dr. Sandy Willson and other leaders of Second Presbyterian.

It was prompted by the hyperpartisan, hateful and hurtful rhetoric heard during the presidential campaign.

It was informed by the tenets of a just and merciful faith.

"The Old Testament mentions the 'sojourner' 92 times and clearly instructs us to be merciful to him," said Willson, senior pastor of Second Presbyterian.

"And Jesus could not have been clearer about that when he told the parable of the Good Samaritan: the neighbor whom God commands us to love cannot be narrowly defined to include only those who share our ethnicity, religion, or nationality."

Willson serves on the board of World Relief, an evangelical organization that has helped thousands of immigrants and refugees resettle in the U.S., including hundreds in Memphis.

Much of that hospitality has been provided by churches such as First Evangelical.

Cole Huffman, senior pastor of First Evangelical, said it was his duty as a Christian and a minister to sign the letter.

"Christ commands us to welcome the stranger and to practice hospitality," he said.

Leaders of local immigrant communities were heartened by the letter.

"Much needed. It gives us renewed hope in America," said Dr. Bashar Shab, chairman of the Memphis Islamic Center.

"This letter gives me hope," said Rondell Trevino, founder of the Memphis Immigration Project.

"Maybe Memphis can help change the narrative of immigration to a positive one in which all immigrants are viewed as human beings made in God's image with tremendous potential."

The chances are more than maybe.

We live in a community where a church welcomed a mosque to the neighborhood. Where a largely evangelical, Pentecostal and African-American population has elected a white Jewish man to Congress and a white Catholic man to the mayor's office.

"Memphis is a welcoming city that values diversity in each and every one of our citizens. And it will continue to be that way," Memphis Mayor Jim Strickland said after the election last November.

Sanctuaries all over town are putting out welcome mats.

"We cannot allow politics to split the Christian family," Willson said.

Too often it does. We all see the world through the partisan political planks in our own eyes.

That's shouldn't prevent the church, every glorious now and then, from rising above partisan politics.

To welcome the stranger, to practice hospitality, and, as the pastors wrote, "to promote the peace and well being of all our citizens."

> "We cannot allow politics to split the Christian family."
>
> DR. SANDY WILLSON
> SENIOR PASTOR OF SECOND PRESBYTERIAN

Classified Legal Notices

Legals

Legal Notices

NOTICE OF FORECLOSURE SALE
STATE OF TENNESSEE, SHELBY COUNTY

WHEREAS, Larry J. Hill and Addie H. Hill executed a Deed of Trust to Crossroads Mortgage Corp., Lender and H. Ray Ashler, Trustee(s), which was dated April 26, 2000 and recorded on April 28, 2000 in Instrument No. K09217, and rerecorded on May 16, 2005 in Instrument No. K1/5028 Shelby County and modified by a Loan Modification Agreement dated September 01, 2012 and recorded on March 21, 2013 in Instrument No. 13014604, Tennessee Register of Deeds;

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, PNC Bank, National Association, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, by an instrument duly recorded in the Office of the Register of Deeds of Shelby County, Tennessee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on **February 2, 2017, at 10:00AM** at the usual and customary location at the Comfort Inn Downtown, 100 N. Front Street, Memphis, TN 38103, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

Lot 58, Phase 3, Diamond Estates Subdivision, as shown on plat of record in Plat Book 141, Page 19, in the Register's Office of Shelby County, Tennessee, reference to which plat is hereby made for a more particular description of said property.

Parcel ID Number: **075259 00034**
Address/Description: **5348 Gemstone Way, Memphis, TN 38109.**
Current Owner(s): **Larry J. Hill and Addie H. Hill**
Other Interested Party(ies): **Gemstone Community Homeowners Association, Inc.; LVDV Funding LLC; and Colorado Capital.**

The sale of the property described above shall be subject to all matters shown on any recorded plat; any and all liens against said property for unpaid property taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; a deed of trust; and any matter than an accurate survey of the premises might disclose; and

All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above.

This office is attempting to collect a debt. Any information obtained will be used for that purpose.

Brock & Scott, PLLC.
Substitute Trustee
c/o Tennessee Foreclosure Department
6 Cadillac Drive, Suite 140
Brentwood, TN 37027
PH: 615-550-7697
FX: 615-550-8434
File No.: 15-03597 FC01

NOTICE OF FORECLOSURE SALE
STATE OF TENNESSEE, SHELBY COUNTY

WHEREAS, WMMC Construction, LLC executed a Deed of Trust to Lima One Capital, LLC, Lender and Lima One Capital, LLC, Trustee(s), which was dated July 10, 2015 and recorded on July 15, 2015 in Instrument No. 15049038, Shelby County, Tennessee Register of Deeds;

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, Lima One Capital, LLC, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, by an instrument duly recorded in the Office of the Register of Deeds of Shelby County, Tennessee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on **January 31, 2017, at 10:00AM** at the usual and customary location at the Shelby County Courthouse, Memphis, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

Lot 37, Hi Point Subdivision, as shown on plat of record in Plat Book 31, Page 24, in the Register's Office of Shelby County, Tennessee, to which plat reference is hereby made for a more particular description of said property.

Being the same property conveyed to WMMC Construction, LLC, from Wealth Marketing Management and Consultants LLC, by Deed dated July 10, 2015 and Recorded July 15, 2015 in Instr #15049037, Shelby County Register's Office.

Legal Notices

State of Tennessee
Property Address: 1723 Corning, Memphis, TN 38127
Parcel# 070054 00008
Parcel ID Number: **070054 00008**
Address/Description: **1723 Corning Avenue, Memphis, TN 38127.**
Current Owner(s): **WMMC Construction, LLC.**
Other Interested Party(ies): **N/A**
The sale of the property described above shall be subject to all matters shown on any recorded plat; any and all liens against said property for unpaid property taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; a deed of trust; and any matter than an accurate survey of the premises might disclose; and

All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above.

This office is attempting to collect a debt. Any information obtained will be used for that purpose.

Brock & Scott, PLLC.
Substitute Trustee
c/o Tennessee Foreclosure Department
6 Cadillac Drive, Suite 140
Brentwood, TN 37027
PH: 615-550-7697
FX: 615-550-8434
File No.: 16-03237 FC01

NOTICE OF FORECLOSURE SALE
STATE OF TENNESSEE, SHELBY COUNTY

WHEREAS, Katrina Young executed a Deed of Trust to Mortgage Electronic Registration Systems, Inc., As Nominee For Ameritrust Mortgage Company, Llc, Lender and Lender's Title & Escrow, LLC, Trustee(s), which was dated May 17, 2005 and recorded on June 2, 2005 in Instrument No. G9965565, Shelby County, Tennessee Register of Deeds;

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, U.S. Bank Trust, N.A., as Trustee for LSF9 Master Participation Trust, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, by an instrument duly recorded in the Office of the Register of Deeds of Shelby County, Tennessee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on **January 31, 2017, at 10:00AM** at the usual and customary location at the Shelby County Courthouse, Memphis, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

Lot 31, Phase 1, Area B, Block 1, Revised Plat Phase 1, South Bluffs, P.D. Subdivision, as shown on plat of record in Plat Book 234, Page 7, in the Register's Office of Shelby County, Tennessee, to which plat reference is hereby made for a more particular description of said lot.

This being the same property conveyed to Katrina Young by Warranty Deed of record at Instrument No. GK-7053, on March 5, 1997 and a Quit Claim Deed of record at Instrument No. KK-2593, on August 7, 2008, in the aforesaid Register's Office.

Parcel ID Number: **092083 00000319**
Address/Description: **629 Montridge Boulevard, Memphis, TN 38103.**
Current Owner(s): **Clemie Howard.**
Other Interested Party(ies): **N/A**
The sale of the property described above shall be subject to all matters shown on any recorded plat; any and all liens against said property for unpaid property taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; a deed of trust; and any matter than an accurate survey of the premises might disclose; and

All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose. THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

Rubin Lublin TN, PLLC. Substitute Trustee1419 S. Main Street, Suite 500Memphis, TN 38103 www.rubinlublin.com/property-listings.php Tel: (877) 813-0992Fax: (404) 601-5846 Ad #106944 01/03/2017, 01/10/2017, 01/17/2017

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to inform interested parties that the Health Services and Development Agency, and all interested parties, in accordance with T.C.A. § 68-11-1609 et seq. and the Rules of the Health Services and Development Agency, that:

Baptist Memorial Hospital-Tipton, a hospital owned by Saint Francis Hospital-Bartlett, Inc., with ownership type of nonprofit corporation, intends to file an application for a Certificate of Need for the establishment of a freestanding emergency department to be located at the intersection of Highway 51 and Tipton Road, in Arlington, Shelby County, Tennessee, on approximately 15 acres. The freestanding emergency department will have 12 treatment rooms and will provide emergency diagnostic and treatment services, including CT, X-Ray, and ultrasound. The project does not involve major medical equipment or services as defined in the 2016 version of the State Health Plan, as amended. The project's total project cost is $[illegible]. The anticipated date of filing the application is on or before January 13, 2017.

The contact person for the project is Jim Parsley, Esq., Bass, Berry & Sims PLC, 150 Third Avenue South, Suite 2800, Nashville, Tennessee 37201, (615) 742-6200.

Upon written request by interested parties, a local fact-finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent and notices that following statutory pursuant to T.C.A. § 68-11-1609(c)(1)(A) any health care institution wishing to oppose a Certificate of Need application and file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is statutorily scheduled and (B) any person wishing to oppose the application and file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

January 10, 2017

Helen Curl

Subscribed and sworn to before me this 10th day of January, 2017.

GLENN W EDWARDS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF SHELBY

Glenn W. Edwards Notary Public

My commission expires January 20, 2020.

JAN 13 '17 PM3:51

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

Kim H. Looney, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of January, 2017 a Notary Public in and for the County/State of Tennessee.
(Month) (Year)

NOTARY PUBLIC

My commission expires: January 8, 2019

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES:
JANUARY 8, 2019

4844-3123-7952.12

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

February 1, 2017

Kim Looney, Esq.
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219

RE: Certificate of Need Application -- Saint Francis Hospital Bartlett - CN1701-004
The establishment a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address at an undeveloped parcel of land located at the southeast corner of I-40 and Airline Road, Arlington (Shelby County), Tennessee. The proposed facility will be operated as a satellite emergency department of Saint Francis Hospital-Barlett, located at 2986 Kate Bond Road, in Bartlett (Shelby County), TN and will have 10 treatment rooms and will provide emergency diagnostic and treatment services. The estimated project cost is $12,857,628.

Dear Ms. Looney:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on February 1, 2017. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on April 26, 2017.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: February 1, 2017

RE: Certificate of Need Application
Saint Francis Hospital Bartlett - CN1701-004

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on February 1, 2017 and end on April 1, 2017.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Kim Looney, Esq.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

JAN 10 '17 PM 1:42

LETTER OF INTENT

The Publication of Intent is to be published in the The Commercial Appeal (Name of Newspaper) which is a newspaper of general circulation in Shelby (County), Tennessee, on or before January 10 (Month/Day), 20 17 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Saint Francis Hospital-Bartlett (Name of Applicant) hospital (Facility Type-Existing)

owned by: Saint Francis Hospital-Bartlett, Inc. with an ownership type of corporation

and to be managed by: itself intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: The establishment of a free-standing emergency department to be located at an undeveloped parcel of land located at the southeast corner of I-40 and Airline Road, in Arlington, Shelby County, Tennessee, on approximately 3.5 acres. The free-standing emergency department will have 12 treatment rooms and will provide emergency diagnostic and treatment services, including CT, X-Ray, and ultrasound. The project does not involve major medical equipment or initiate or discontinue any other health service or affect the hospital's licensed bed complement. The cost of this project is expected to be approximately $13,931,246.70.

The anticipated date of filing the application is: On or before January 13, 20 17

The contact person for this project is Kim Harvey Looney, Esq. (Contact Name) Attorney (Title)

who may be reached at: Waller Lansden Dortch & Davis LLP (Company Name) 511 Union Street, Suite 2700 (Address)

Nashville (City) TN (State) 37219 (Zip Code) 615 (Area Code) / 850-8722 (Phone Number)

Kim H. Looney (Signature) January 10, 2017 (Date) Kim.Looney@wallerlaw.com (Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1

-Original-

St Francis Hospital Bartlett

CN1701-004

waller

JAN 30 '17 AM 11:56

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

SUPPLEMENTAL #1
January 30, 2017
11:56 am

January 30, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Saint Francis Hospital-Bartlett CN1701-004

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 25, 2017, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. **Section A., Applicant Profile, Item 1 and 2**

   The address of the proposed project does not match the address provided in the applicant's Letter of Intent (LOI). Please provide the address of the proposed project.

   The address of Waller Lansden Dortch & Davis LLP is noted. Please list Suite #2700 consistent with the LOI.

   Please provide the above two corrections and submit a replacement page #1.

   Response: Both of these corrections have been made. Please see replacement page 1 included as Attachment Section A, Applicant Profile, Items 1 and 2.

2. **Section A., Executive Summary A, Item 1**

   Please clarify if an ambulance will be stationed at the satellite ED 24 hours/day, 7 days/week, 365 days/year for life-threatening transports to full service hospitals.

   Response: SFH-Bartlett has contracts with both MedicOne Medical Response and Emergency Mobile Health Care to provide patient transport services. Each has availability for 24 hours/day, 7 days/week, 365 days/year for life-threatening transports to a full service hospital. The applicant anticipates an ambulance will be on site through one of these providers.

Please clarify if the proposed project will include a helipad. If a helipad has not been planned for this facility, please briefly describe the reasons that air transport may not be necessary for transfer of Level IV or V patients who require immediate air evacuation to major trauma centers.

Response: As shown on the plot plan, the project design includes a helipad to ensure availability of immediate air evacuation for patient care. Construction costs of the helipad are included in the project cost estimates.

3. **Section A., Executive Summary A, Item B.1. Rationale for Approval, 1. Need**

On the bottom of page 4 the applicant projects 5,550 visits in the first full year of 2019. However, the Projected Data Chart projects 5,591 ED visits. Please clarify.

Response: The correct number of visits in the first full year of operation of the FSED should be 5,591. Please see a corrected Executive Summary, including page 4, included as Attachment Section A, Executive Summary A, Item B.1. Rationale for Approval, 1. Need.

4. **Section A, Project Details, Item 4.A Legal Interest**

The option to lease is noted. However, please provide a fully executed option to lease signed by the applicant.

Response: See fully executed option to lease included as Attachment Section A, Project Details, Item 4.A. Please note that this option should replace the one included in the original filing.

It is noted the Option to Lease agreement is with the real estate developer Capital Growth Medvest, LLC. However, please provide documentation that Capital Growth MedVest, LLC has legal possession of the proposed site. Also, please provide a copy of a current deed to confirm ownership.

Response: The land that is intended to be purchased is contained in two parcels. Capital Growth Medvest, LLC has a Purchase and Sale Option for each. One is with P.F. Holdings, Inc. and one is with T. David Goodwin, Sr., T. David Goodwin, Jr. and Hyneman Holdings, LLC. Both were executed on January 5, 2017. See both of these Purchase and Sale Agreements included as Attachment Section A, Project Details, Item 4.A.

5. **Section A, Project Details, Item 6 B. (2) Floor Plan**

Please complete the chart below:

Patient Care Areas other than Ancillary Services	# Hospital ED	# Satellite ED	# Combined EDs
Exam/Treatment Rooms	25	9	34
Multipurpose			
Gynecological	1	1	2
Holding/Secure/Psychiatric	2	1	3
Isolation	1	1	2
Orthopedic	1		1
Trauma	3	1	4
Other			
Triage Stations	3 not rooms	1 not rooms	4 not rooms
Decontamination Rooms/Stations	1 not rooms	1 not rooms	2 not rooms
Total	33	13	46
Useable SF of Main and Satellite ED's	*18,500 sq. ft.	11,109 sq. ft.	29,609 sq. ft.

* CT, Ultrasound, and Laboratory are not included within the 18,500 sq. ft.

6. **Section B, Need, Item 3. (Proposed Service Area)**

The zip code service map is noted in Attachment Section C-Need-3. However, please provide a zip code service area map that includes all four counties in the proposed service area. This will give Agency members an overall clear picture of where the zip code service area is in relation to the proposed overall four county service area.

Response: Please see revised zip code service area map included as Attachment Section B, Need-Item 3.

The utilization table on page 17 is noted. However, the total utilization in Year 1 for SFH-Bartlett of 43,823 appears incorrect. Please correct and submit a replacement page 17.

Response: See revised page 17 correcting Year 1 totals for SFH-Bartlett and Year 1 totals for the proposed FSED included as Attachment Section B, Need-Item 3.

7. **Section B, Need, Item 3 (2).**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the table below and include data for each zip code in your proposed service area.

waller

Variable	*Zip Code*								
	38002	***38012***	***38028***	***38049***	***38053***	***38054***	***38060***	***38068***	***38069***
Current Year (CY), Age 65+	4,143	2,287	1,058	705	4,601	N/A	1,477	1,999	444
Projected Year (PY), Age 65+	5,120	2,716	1,305	867	5,487	N/A	1,640	2,314	560
Age 65+, % Change	23.6%	18.8%	23.3%	23.0%	19.3%	N/A	11.0%	15.8%	26.1%
Age 65+, % Total (PY)	11.8%	18.4%	18.1%	17.4%	18.4%	N/A	14.9%	21.1%	21.4%
CY, Total Population	41,561	14,763	6,498	4,940	29,390	63	10,512	10,865	2,615
PY, Total Population	43,413	14,785	7,197	4,981	29,794	63	10,982	10,955	2,612
Total Pop. % Change	4.5%	.1%	3.6%	1%	1.4%	0%	4.5%	1%	0%
TennCare Enrollees	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TennCare Enrollees as a % of Total Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Median Age	37.5	39.9	48.8	41.5	40.2	24.0	37.4	42.5	38.0
Median Household Income	$93,603	$33,650	$93,892	$35,826	$51,423	$86,750	$64,636	$41,048	$33,784
Population % Below Poverty Level	5.0%	23.9%	23.9%	22.3%	16.3%	0.0%	6.1%	18.2%	23.3%

Note: Zip Code 38054 is a zip code for a military base. As such, some data is unavailable for this particular zip code. The applicant has included it in the service area because it has patients from that zip code.

Please see revised page 20 for additional information included as Attachment Section B, Need, Item 3 (2).

8. Section B, Need, Item 3.A (1.) (Proposed Service Area)

Please describe the demographics of the population to be served by the proposal.

Response: The service area is a mixture of high growth suburban areas and aging rural communities. The overall zip code service area population is expected to grow 2.9% between 2017 and 2021. The population aged 65 and older is expected to grow at the fastest rate during this same time period at almost 20%. It is this older population that is the most at risk and needs lifesaving emergency care close to home the most. The proposed FSED addresses access to the outlying areas, by not only being closer to the center of this population than the existing hospitals, but also by being located at the intersection of two major highways - I40 and I269.

This location is a natural extension of the SFH-Bartlett emergency room which is approximately 9 miles away. As the closest full service hospital and ED, SFH-Bartlett already cares for the largest portion of the population seeking emergency services in the proposed zip code service area. SFH-Bartlett had a 28% market share of the emergency patient visits in 2015, higher than any other hospital in any of the counties that represent the zip codes in the service area, which includes Shelby and Tipton. Baptist Memorial Hospital had a 9% market share and Regional One had a 2% market share in the applicants' proposed zip code service area in 2015.

Market Share by Facility

Facility	Market Share in Service Area
Saint Francis Hospital-Bartlett	28%
BMH-Memphis	9%
Regional One Health	2%

Distance from Proposed FSED

Facility	Miles from I-40 and Airline Road
Saint Francis Hospital-Bartlett	9
BMH-Memphis	18
Regional One Health	28

9. **Section B, Need, Item 3.(b) (Proposed Service Area)**

The Emergency Department Utilization table for 2013-2015 on page 22 reflecting 42,220 ED visits for SFH-Bartlett is noted. However, the 2015 SFH-Bartlett Joint Annual Report page 38 indicates 46,742 patients presented in the ED and 45,572 were treated. Please clarify.

Response: The numbers reported on the JAR are incorrect. The numbers reported in the application are correct. The applicant has submitted a request to the Department of Health to correct the JAR. Please see revised page 22 and copy of letter included as Attachment Section B, Need, Item 3.(b) (Proposed Service Area).

10. **Section B, Need, Item 5.**

The utilization table of SFH-Bartlett's admission, patient days, and occupancy rate on the bottom of page 23 is noted. However, please address this question in relation to the SFH-Bartlett's main ED and proposed Satellite ED's utilization (visits).

Response: Please see table below which addresses the utilization at SFH-Bartlett for the years 2013-2019. A table which combines the data for the SFH-Bartlett ED and the proposed Satellite ED is also included.

Saint Francis Hospital-Bartlett ED
Utilization Data

Year	Number Treatment Rooms	Visits	Visits/Room
2013	33	36,001	1,091
2014	33	38,375	1,163
2015	33	42,220	1,279
2016	33	43,644	1,323
2017	33	45,826	1,389
2018	33	47,659	1,444
2019	33	49,565	1,502

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015. Internal data from SFH-Bartlett. Projections based on historical data.

Note: The table above assumes no future change in bed count, so the data does not match the table below.

Saint Francis Bartlett Hospital ED Historical and Proposed Satellite ED Projected Utilization

	Actual			Projected		
Year	**2014**	**2015**	**2016**	**Yr 1**	**Yr.2**	**Yr. 5**
Main Campus Visits	38,375	42,220	43,644	46,193	46,681	48,302
Main Campus Rooms	33	33	33	33	33	33
Main Campus Visits/ Room	1,162	1,279	1,323	1,400	1,415	1,464
Satellite Visits				5,591	6,656	9,980
Satellite Rooms				13	13	13
Satellite Visits Per Room				430	512	**768**
Total Visits	38,375	42,220	43,644	51,784	53,337	58,282
Total Rooms	33	33	33	46	46	46
Total Visits Per Room	**1,162**	**1,280**	**1,323**	**1,126**	**1,160**	**1,267**

Note: Project 1st Year will be 2019

Please identify existing urgent care centers in the applicant's zip code service area by completing the following table.

Urgent Care Centers in Applicant's Proposed Zip Code Service Area

Urgent Care Center Name	Address	Distance from Proposed ED	Operating Hours	Medicare, TennCare & Major Ins Accepted?
Fast Pace Urgent Care Clinic	1137 South Dupree St., Ste 400 Brownsville, TN 38012	34 Miles	8:00 to 8:00 M – F 8:00 to 6:00 Saturday 1:00 to 5:00 Sunday	Yes
Fast Pace Urgent Care Clinic	8188 Highway 51 North Millington, TN 38053	19 Miles	8:00 to 8:00 M – F 8:00 to 6:00 Saturday 1:00 to 5:00 Sunday	Yes
People First Urgent & Primary Care	4772 Navy Road Millington, TN 38053	17 Miles	8:00 to 8:00 M – F 10:00 to 6:00 Saturday 12:00 to 5:00 Sunday	Yes

Please complete the following table for the historical and projected ED volumes of SFH-Bartlett from 2014-2017 by level of care consistent with CPT codes 99281 (lowest acuity), 99282, 99283, 99284 and 99285 (highest acuity patient).

SFH-Bartlett Historical and Projected Utilization by Level of Care

Level of Care	Main ED	Main ED	Main ED	Main ED	Satellite ED	Combined Year 1
	2014	2015	2016	Year 1	Year 1	
Level I	1,604	894	743	786	1,230	2,016
Level II	2,634	3,322	3,300	3,493	1,677	5,170
Level III	12,070	13,605	13,420	14,204	1,789	15,993
Level IV	15,576	14,903	15,460	16,363	839	17,202
Level V	6,491	9,496	10,721	11,347	56	11,403
Total	38,957	42,220	43,644	46,193	5,591	51,784

waller

Please complete the following chart for projected ED utilization by zip code in Year 1 of the proposed Satellite ED project for zip codes with patient origin over 0.15%.

Projected Utilization by Zip Codes in Applicant's Proposed Service Area, Year 1

Patient Zip Code	Name	Population	Main ED Visits Year 1	Proposed Satellite ED Visits Year 1	Total ED Visits	% by Zip Code	Cumulative %
38002	Arlington	41,561	4,562	1,939	6,501	37%	37%
38028	Eads	6,498	486	308	794	5%	42%
38053	Millington	29,390	2,037	1,312	3,349	19%	61%
38060	Oakland	10,512	2,553	817	3,369	19%	80%
38068	Somerville	10,865	1,616	596	2,212	13%	93%
38012	Brownsville	14,763	80	163	244	1%	94%
38069	Stanton	2,615	88	151	239	1%	95%
38049	Mason	4,940	544	305	849	5%	100%
Total		122,253	11,966	5,591	17,557	N/A	N/A

11. Section B, Economic Feasibility, Item 2.

The applicant notes Tenet has a line of credit available for undertaking projects such as the proposed FSED. Please provide a letter from the institution of the available line of credit, expected interest rates, anticipated term, and any restriction or conditions.

In addition, please specify the percentage of project funding from cash reserves and from the available line of credit.

Response: The applicant anticipates that 100% of the funding for this project will come from the cash reserves rather than the line of credit. A copy of the letter regarding cash reserves is included as Attachment Section B, Economic Feasibility, Item 2.

12. Section B. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

The Historical Data Chart for the total facility is noted. Please correct the following and submit a revised Historical Data Chart:

- There appears to be calculation errors in the 2013 Gross Operating Revenue total of $634,891,175.
- Please complete Section G. Other Deductions.
- The totals for "Other Expenses" of $3,913,934 for 2013, $4,968,699 for 2014, and $5,468,552 for 2015 do not match line D.6 in the Historical Data Chart.

Response: See revised pages 28 and 29 Historical Data Chart for total facility included as Attachment Section B, Economic Feasibility, Item 4.

Please submit a Historical Data Chart for the applicant's existing Emergency Department.

Response: See Historical Data Chart for the applicant's existing Emergency Department included as Attachment Section B, Economic Feasibility, Item 4.

Please submit a Projected Data Chart for the hospital SFH-Bartlett.

Response: See Projected Data Chart for SFH-Bartlett for the entire facility included as Attachment Section B, Economic Feasibility, Item 4.

The Projected Data Chart for the proposed project is noted. However, line E. (Earnings Before Interest, Taxes and Depreciation) for Year One and Year Two is incorrect. Please revise and submit a revised Projected Data Chart.

The total for "Other Expenses" of $323,801 for Year One and $333,516 in Year Two is noted. However the totals do not match line D.6 for both years in the Projected Data Chart. Please clarify.

Response: See revised pages 31 and 32 Projected Data Chart for the proposed project included as Attachment Section B, Economic Feasibility, Item 4.

13. Section B. Economic Feasibility Item 5A. and 6.B

The Gross Charge, Deductions from Revenue, and Average Net Charge does not match the Projected Data Chart. Please revise.

If there are any changes in the Projected Data Chart as a result of a calculation error, the projected average gross charge per patient/visit, projected deduction from revenue per patient/visit, and the projected net charge per patient/visit may change. If needed, please revise the applicant's response to Item 5 A. and 6.B if there are any changes in the Projected Data Chart that will change the gross charge, deductions from revenue, average net charge, or Net Operating Ratio.

Response: See revised page 33 included as Attachment Section B, Economic Feasibility, Items 5.A and 6.B.

14. Section B. Economic Feasibility Item 6.A, 6.B, 6.C

Please clarify how the applicant expects to break even in Year One while experiencing a ($743,545) loss.

Response: Please see corrected Projected Data Chart for the proposed Satellite ED. Based on the corrected Projected Data Chart, the applicant anticipates a Net Loss of $503,596 and a negative Free Cash Flow of $269,596 in the first year of operation. It is not until the second year that the applicant will break even and have a positive Net Income of $589,103, with a Free Cash Flow of $823,103.

The Net Operating Margin Ratio table is noted. However, the table may need to be adjusted to reflect any changes in the Historical or Projected Data Charts. If needed, please revise.

Response: Please see revised page 34 for the revised Net Operating Margin table included as Attachment Section B, Economic Feasibility, Item 6.A., 6.B., 6.C.

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet.

Response: The applicant believes the capitalization ratio to be 95% based on the Tenet 10Q for the quarterly period ended September 30, 2016, which is the latest data available.

15. Section B. , Orderly Development, Item 1

Please list all existing health care providers, managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to this project, such as , transfer agreements, contractual agreements for health services.

Response: As an outpatient department of SFH-Bartlett, the proposed FSED will have any and all relationships, contractual or working, that SFH-Bartlett has. SFH-Bartlett is contracted with the following health care providers for professional services: Tennessee Emergency Physicians (Apollo); Memphis Physicians Radiological Group; East Memphis Anesthesia Services; The Pathology Group; and SMZ Specialists (Pulmonary/Critical Care). The applicant is also including a letter that was presented to the HSDA during the hearing of the Baptist Memorial Hospital-Lakeland CON, CN1508-037D, which describes some of the relevant requirements in order for an outpatient department of a hospital to meet the CMS provider-based rules. The proposed FSED meets any and all of the requirements. Please see Attachment B, Orderly Development, Item 1 for a list of some of the Managed Care Organizations, and a copy of the provider-based letter prepared by Waller in 2016. These rules have not changed with respect to outpatient departments of a hospital such as the proposed FSED.

Please discuss how patients that present at the proposed Satellite ED with acute cardiac symptoms will be treated and/or referred. How will the applicant handle transfer agreements.

Response: SFH-Bartlett is an Accredited Chest Pain Center. As an outpatient department of SFH-Bartlett, the FSED will utilize the same protocols as SFH-Bartlett. Once emergency medicine physicians have determined a patient requires cardiac intervention, the cath lab will be activated and the patient will be transported via ambulance directly to the cath lab at SFH-Bartlett, approximately 9 miles, or a matter of minutes away. Because the FSED is located directly off I40, with only 1 traffic light between it and I40, and SFH-Bartlett is also located only 1.4 miles off of I40, there would not be expected to be any significant delay in transport as a result of any traffic issues. This is the same procedure that would be followed if a patient presented at the SFH-Bartlett ED and the emergency medicine physician determined that the

patient requires cardiac intervention. In both situations, the cath lab would be ready for the patient upon his/her arrival. There is no delay in treatment as a result of the transfer either from the FSED or the SFH-Bartlett ED to the SFH-Bartlett cath lab. SFH-Bartlett is the closest hospital to the site for the proposed FSED.

16. Section B. , Orderly Development, Item 4.A and 4.B

Please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency. The referenced attachment could not be located.

Response: See most recent statement of deficiencies/plan of correction and letter from Tennessee Department of Health noting no deficiencies included as Attachment Section B, Orderly Development, Items 4.A and 4.B.

17. Project Completion Forecast Chart

Please complete #11 (Issuance of License) and #12 (Issuance of Service) of the Project Completion Forecast Chart and resubmit.

Response: See revised page 44 Project Completion Chart included as Attachment Section B, Orderly Development, Project Completion Forecast Chart.

Please contact me if you have any questions or need additional information or clarification.

Sincerely,

Kim Harvey Looney

KHL:lag
Attachments

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section A, Applicant Profile, Items 1 and 2

Revised Page 1

SUPPLEMENTAL #1
January 30, 2017
11:56 am

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. ***Name of Facility, Agency, or Institution***

Saint Francis Hospital-Bartlett
Name

Southeast Corner of I-40 and Airline Road — Shelby
Street or Route — County

Arlington — TN — 38133-4003
City — State — Zip Code

Website address: https//www.saintfrancisbartlett.com

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. ***Contact Person Available for Responses to Questions***

Kim Harvey Looney — Attorney
Name — Title

Waller Lansden Dortch & Davis LLP — kim.looney@wallerlaw.com
Company Name — Email address

511 Union Street, Suite 2700 — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Attorney — 615-850-8722 — 615-244-6804
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

SUPPLEMENTAL #1

January 30, 2017
11:56 am

Attachment Section A, Executive Summary A, Item B.1 Rationale for Approval, 1

Revised Pages 2-5

Executive Summary

1. SECTION A: EXECUTIVE SUMMARY - REVISED

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: The applicant is seeking to establish a freestanding emergency department, which will be an outpatient department of Saint Francis Hospital - Bartlett, with the same licensure classification as the main emergency department on the campus of SFH-Bartlett. The FSED will include certain diagnostic imaging equipment necessary for the operation of an FSED including CT, X-Ray and ultrasound. The FSED is being built with 12 treatment rooms and 1 trauma bay, and will staff and operate them in accordance with needs of the service area residents. The proposed FSED is located approximately 9 miles from SFH-Bartlett, which is the closest hospital. The FSED will be operated 7 days a week, 24 hours a day, 365 days a year. An ambulance will be available either on-site or on call from either MedicOne Medical Response or Emergency Mobile Health Care to provide transports to the nearest full-service hospital. The proposed FSED will include a helipad to ensure availability of immediate air evacuation for patient care. No health services will be initiated, and no beds are affected as a result of this application. The applicant has no outstanding but unimplemented CONs.

2) Ownership structure;

Response: The FSED will be an outpatient department of SFH-Bartlett and as such, will have the same ownership structure as the hospital. It will comply with all of the CMS provider-based regulations.

3) Service area;

Response: The service area includes portions of Shelby, Fayette, Haywood and Tipton Counties. Specifically it includes nine (9) zip codes: 38002, 38028, 38053 and 38054 (Shelby County), 38060 and 38068 (Fayette County), 38012 and 38069 (Haywood County), and 38049 (Tipton County). The applicant determined the service area based on the areas surrounding the proposed site in which it has significant market share. For its proposed zip code service area, SFH-Bartlett has the highest market share, at 28% in 2015. Baptist Memorial Hospital has 9% and Regional One has 2% market share in this service area for the same time period. In addition, the applicant determined that neither the zip code in which SFH-Bartlett is located (38133), nor the one immediately adjacent to 38133 (38135), were appropriate to be included in the service area for the FSED. Patients from both of these zip codes would have to travel past SFH-Bartlett, a full-service hospital with an ED, to receive services at the FSED, which is unlikely, given the nature of the services.

4) Existing similar service providers;

Response: None of the service area counties currently have an FSED. The only hospital in the zip code service area is SFH-Bartlett, so it provides the only

emergency department services. Utilization for Shelby County providers and the hospital in Tipton County are included in the application because portions of those counties are included in the service area. Overall, utilization for emergency services is growing at these hospitals. Utilization ranged from 1,026 per treatment room to 1,966 per treatment room for 2015 for these facilities. There are no hospitals in Fayette or Haywood counties. Haywood Park Community Hospital closed in 2014 and Methodist Fayette closed in 2015, leaving those communities without convenient access to emergency services. The last full year before they closed, Haywood Park reported 5,460 emergency department visits and Methodist Fayette reported 7,580 emergency department visits, for a total of 13,040 visits. In 2015, SFH-Bartlett had 1,280 visits per treatment room, increasing to 1,323 visits per treatment room for 2016. SFH-Bartlett expects to have greater than 1,500 visits per treatment room no later than 2019.

5) Project cost;

Response: The applicant estimates the project costs to be $12,828,763, of which $5,352,475 are the construction costs, or $351.21 per square foot. This compares favorably both to the construction data on the Applicant's Toolbox on the HSDA website, as well as recently approved FSEDs. Capital Growth MedVest intends to develop the project and the applicant intends to lease the building from them. The applicant is only responsible for the funding of the costs of the fixed and moveable equipment of approximately $2.3M.

6) Funding;

Response: The applicant anticipates its portion of the costs - the fixed and moveable equipment of $2.3M - will be funded from cash reserves. The majority of project costs will be paid from operating revenues after the project is operational, through a lease with MedVest.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: The applicant anticipates that the FSED will generate a positive cash flow during its second year of operation.

8) Staffing.

Response: The applicant anticipates providing 27.59 FTE direct patient care staff, including RNs, triage nurses, and lab and radiology technicians. There will be 6.2 FTE patient care positions, including directors/administrators, secretaries and front desk positions. In addition there will be 13.0 FTE contractual staff. Tenet is a national corporation with the capability to recruit professionals as needed on a national or international level, as required. The applicant anticipates no difficulty in staffing these positions.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the

data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: The applicant, SFH-Bartlett, is an acute care hospital with 196 licensed beds. In 2013, it increased its emergency department treatment rooms from 19 to 33. From 2013 to 2016, its utilization increased from 36,616 visits to 43,644 visits, or an increase of 19%. In 2016, the number of visits per treatment room was 1,323. At this rate of growth, SFH-Bartlett will exceed 1,500 visits per treatment room in the hospital ED as of 2019. The planning horizon for the project is 4 years out, or 2021, so it is important to consider what resources might be needed in that year and beyond. Given its existing and projected utilization, SFH-Bartlett will need additional ED capacity in the next couple of years. It is not possible to increase space for the ED within the existing footprint of SFH-Bartlett. To add capacity would require major construction and be extremely disruptive to patients, family members and staff during the process. SFH-Bartlett is seeking to add additional ED capacity to its service area as well as to bring an essential health care service closer to the primarily rural patient population that is in need of that service. The population aged 65 and older is expected to increase 20% during this time period and it is this patient population that is most in need of immediate access to emergency services.

The FSED will be located off of I40 and Airline Road in Arlington, approximately 9 miles from the SFH-Bartlett campus. This location is 1.3 miles from the Fayette County border and because of its proximity to I40 and other major Shelby County highways, it is expected to provide faster access to emergency services. It is important that area residents have convenient access to emergency services as time to treatment is generally a critical factor in providing emergency care.

The State is in the process of developing the Memphis Regional Megasite. This site is a 4,100 acre site backed by a $106 million State infrastructure investment. It is located off of I40 approximately 18 miles from the proposed FSED site. It will be extremely beneficial to recruiting businesses to locate here for their workers to have convenient access to health care services. Any growth in population is not included in any current population projections and it would be expected that as industry locates at this site, they will bring a significant workforce with them, increasing the need for the proposed FSED.

The FSED will include certain diagnostic imaging equipment necessary for the operation of an FSED including CT, X-Ray and ultrasound. The FSED will be built with 12 treatment rooms and 1 trauma bay, and it be will staffed and operate as many treatment rooms as are necessary to meet the needs of the service area population. By adding an FSED, SFH-Bartlett will be able to add to its capacity for ED services, while at the same time locating the service closer to a patient population which is in need of these services. There are no FSEDs in the applicant's service area. The only hospital in the zip codes for the applicant's service area is SFH-Bartlett.

Utilization for Shelby County providers and the hospital in Tipton County is included in the application because portions of those counties are included in

the service area. Overall, utilization for emergency services is growing at these hospitals; it ranged from 1,026 visits per treatment room to 1,966 visits per treatment room for 2015. The applicant's service area lost 2 hospital providers in recent years. Haywood Park Community Hospital closed in 2014 and Methodist Fayette closed in 2015, leaving those communities without convenient access to emergency services. The last full year each of the hospitals was open, there was a combined 13,040 visits in their emergency departments. This project seeks to help fill the void in availability of emergency services and increase access for emergency services by providing another option in close proximity to the service area residents.

The applicant projects 5,591 visits the first full year of operation (2019) increasing to 6,656 visits the second full year of operation (2020), with 25% or more of those coming from patients who would otherwise choose to receive services from SFH-Bartlett. The FSED is being built with 12 treatment rooms, and 1 trauma bay, and SFH-Bartlett will staff and operate them in accordance with needs of the service area residents. As utilization at SFH-Bartlett increases, it is important to expand the services and options available for emergency services. An FSED is a viable option to provide increased capacity for ED services. Locating the FSED a little over 9 miles away from SFH-Bartlett also allows for increased access by patients who might otherwise have to travel farther to receive these services, providing a viable option and allowing for patient choice.

2) Economic Feasibility;

Response: The applicant estimates the project costs to be $12,828,763, of which $5,352,475 are the construction costs. The total square footage is 15,240 square feet, for a cost per square foot of $351.21. The median square footage cost for hospital projects from 2013-2015 is $308.43, while the 3rd quartile for square footage cost for hospital projects is $374.32. Thus, the applicant's projected square footage construction cost is less than the 3rd quartile for hospital projects based on data from 2013-2015. Several FSEDs have been approved in Tennessee in recent years - CN1202-008A for Horizon Medical Center in Dickson ($295 per square foot); CN1508-029 for Sumner Regional Medical Center ($288 per square foot); and CN1508-031 for TriStar Summit Medical Center ($374.32 per square foot). The applicant's construction costs are reasonable and compare favorably to other FSED projects that have been approved by the HSDA.

Capital Growth MedVest intends to develop the project and the applicant intends to lease the building from them. The applicant is only responsible for the funding of the costs of the fixed and moveable equipment of approximately $2.3M, which will be funded from cash reserves.

The applicant anticipates that the project will have a positive cash flow in the second full year of operation.

3) Appropriate Quality Standards; and

Response: The applicant will measure certain quality standards for the FSED, similar to those applied to the SFH-Bartlett ED, including potentially some of the following: aspirin at arrival, door to diagnostic evaluation by a qualified medical

personnel, median time from ED arrival to departure for discharged ED patients, median time transfer to another facility for acute coronary intervention and median time to pain management for long bone fracture.

4) Orderly Development to adequate and effective health care.

Response: The proposed FSED contributes to the orderly development of adequate and effective health care. SFH-Bartlett is the closest hospital to the FSED. At just over 9 miles from SFH-Bartlett, the FSED is located far enough away to provide increased access for significant portions of the service area population. SFH-Bartlett estimates that at least 25% of the patients for this FSED will be a patient population it already serves who will choose to receive these emergency services closer to home. With the dominant share of the market in the service area at 28%, SFH-Bartlett is the logical choice to develop such a project.

Market Share by Facility

Facility	Market Share in Service Area
Saint Francis Hospital-Bartlett	28%
BMH-Memphis	9%
Regional One Health	2%

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section A, Project Details, Item 4.A

Option to Lease

Purchase and Sale Agreements

SUPPLEMENTAL #1
January 30, 2017
11:56 am

OPTION TO LEASE AGREEMENT

THIS OPTION TO LEASE AGREEMENT (the "Agreement") is made and entered into as of this _____ day of January, 2017, by and between Capital Growth MedVest, LLC, an Alabama limited liability company ("Landlord") and Saint Francis Hospital-Bartlett, Inc., a Tennessee for profit corporation ("Tenant").

WITNESSETH

WHEREAS, Landlord has plans to construct a building located off I40 and Airline Road, Arlington, Shelby County, Tennessee (the "Property"); and

WHEREAS, Landlord desires to enter into an option with Tenant whereby Landlord grants to Tenant the option to lease approximately 15,240 square feet of the Property (the "Leased Premises"), which option must be exercised as set forth below.

NOW, THEREFORE, for and in consideration of the mutual promises set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1
GRANT OF OPTION

1.1 Landlord hereby grants to Tenant an exclusive option to lease the Leased Premises, upon the terms and conditions set forth herein.

1.2 The term of Tenant's option to lease the Leased Premises shall commence on the date hereof and shall continue for a period of six (6) months from the date hereof (the "Option Period"). The Option Period may be extended at any time prior to its expiration upon the mutual consent of the parties.

1.3 Tenant shall exercise its option to lease the Leased Premises by delivering written notice to Landlord within the Option Period by Registered or Certified Mail, or in person.

1.4 The parties agree hereto that this option to lease is contingent upon the Tenant obtaining a Certificate of Need to establish a standalone emergency department from the State of Tennessee Health Services and Development Agency which is not subject to a contested case hearing.

SECTION 2
TERMS AND CONDITIONS OF THE LEASE

2.1 The parties agree to execute a formal lease agreement, subject to any terms and conditions contained in this Agreement and as mutually agreed upon by the parties. The rent shall be based upon a yield of 8.50% of actual project costs that fall within an approved budget. Based on the current budget the initial rent would be $52.88 per square foot. Landlord will endeavor to reduce costs throughout the diligence and planning process.

2.2 The term of Tenant's lease of the Leased Premises shall be for a period of fifteen (15) years (the "Term"), with multiple renewal options.

SECTION 3
MISCELLANEOUS PROVISIONS

3.1 Any notices require or permitted herein shall be addressed as follows and delivered to the other party by either registered or certified mail, facsimile, or in person:

If to Landlord:

Capital Growth MedVest, LLC
361 Summit Blvd., Suite 220
Birmingham, Alabama 35243
Attn: David S. Fowler

If to Tenant:

Saint Francis Hospital-Bartlett
1445 Ross Avenue, Suite 1400
Dallas, TX 75202
Attn: Director of Real Estate

With a copy to:

Waller Lansden Dortch & Davis LLP
511 Union Street
Suite 2700
Nashville, TN 37219
Attn: Kim H. Looney, Esq.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

LANDLORD:
Capital Growth MedVest, LLC

By: _____
Title: Manager

TENANT:
Saint Francis Hospital - Bartlett

By: _____
Title: CEO, Central Division

SUPPLEMENTAL #1
January 30, 2017
11:56 am

PURCHASE AND SALE AGREEMENT

THIS PURCHASE AND SALE AGREEMENT (this "Agreement") is made and entered into by and between **CAPITAL GROWTH MEDVEST, LLC**, an Alabama limited liability company, or its affiliate or assign ("Buyer"), and **P.F. HOLDINGS, INC.** (collectively, "Seller").

WITNESSETH:

For the covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Seller and Buyer agree as follows:

1. **Sale and Purchase**. Subject to and in accordance with the terms of this Agreement, Seller agrees to sell to Buyer, and Buyer agrees to purchase from Seller, certain real property located along New Airline Road in Memphis, Tennessee, containing approximately 1.5 acres as depicted on **Exhibit A** attached hereto and made a part hereof, together with all improvements, rights, easements, interests, privileges, tenements and hereditaments appurtenant thereto (collectively, the "Property").

2. **Purchase Price**. At the closing and consummation of the transaction contemplated by this Agreement (the "Closing"), Buyer shall pay Seller the sum of Eight Hundred Fifty Thousand and 00/100 Dollars ($850,000.00) for the Property (the "Purchase Price"), in immediately available funds, less the amount of any credits or adjustments provided for herein.

3. **Earnest Money**. Within five (5) business days after the Effective Date (hereinafter defined in Section 23), Buyer shall deliver to Stewart Title Guaranty Company National Title Services, 5901 Peachtree Dunwoody Road, Suite A-350, Atlanta, Georgia 30328, Attention: Robert (Rob) M. Reeder (the "Title Company"), the sum of Ten Thousand and No/100 Dollars ($10,000.00), which amount, plus any interest earned thereon, is referred to as the "Earnest Money." The Earnest Money shall be credited against the Purchase Price at Closing. In the event that this Agreement shall be terminated during the Inspection Period, the Earnest Money shall be refunded in accordance with Section 4 below.

4. **Inspection**.

(a) For purposes of this Agreement, the term "Inspection Period" shall mean and refer to the period commencing on the Effective Date and expiring at 11:59 p.m. central time on the date that is one hundred twenty (120) days after the last to occur of (i) the Effective Date, or (ii) the date the Property is fully accessible by vehicle from a public right-of-way and in suitable condition for Buyer to perform, without interference, interruption, or unusual cost, all inspections, tests, and investigations of the Property deemed necessary or appropriate by Buyer. Buyer and Buyer's agents and third-party consultants shall have access to the Property to conduct all inspections. Inspections conducted by Buyer may include, but are not limited to, evaluation of: (i) current zoning and required rezoning for intended use, (ii) soil conditions, (iii) environmental conditions, (iv) traffic impact, (v) utility availability, (vi) storm water retention, (vii) archaeological considerations, (viii) servitudes, (ix) endangered species, (x) wetlands, (xi) flood zone, (xii) buffer/setback requirements, (xiii) fire access requirements, (xiv) access, (xv)

survey, (xvi) local building ordinances and restrictions, (xvi) signage rights, and any other matter Buyer deems relevant. Buyer shall indemnify, protect, defend and hold harmless Seller from and against any and all losses, claims, damages and costs (including court costs and reasonable attorneys' fees) arising out of any claims made solely in connection with Buyer's access to, entry upon, inspection and/or testing of the Property, except to the extent such claims are caused by the negligence of Seller. The discovery of hazardous materials or releases, title defects, unsafe conditions, etc., and the reporting of same and the incursion of fines or costs by Seller to remedy same shall not constitute harm to Seller.

(b) Buyer may terminate this Agreement for any reason, or for no reason, in its sole and absolute discretion, by giving written notice to Seller on or before the date and time the Inspection Period expires. In the event that this Agreement shall be terminated by Buyer during the Inspection Period, the Earnest Money shall be immediately refunded to Buyer in full.

5. **Title and Survey Matters.**

(a) Prior to the expiration of the Inspection Period, Buyer shall order a commitment for an ALTA Owner's Extended Coverage Policy of Title Insurance (Form 2006) from an agent of Title Company selected by Buyer, showing the status of title to the Property (the "Commitment"). At Buyer's discretion, Buyer may all also order a current ALTA survey of the Property (the "Survey") certified to Buyer, Seller and the Title Company. The Commitment shall be in the amount of the Purchase Price and shall commit to insure the Buyer has good and marketable fee simple absolute title to the Property. If Buyer has any objections to the status of title to the Property (including, but not limited to, the exceptions and requirements set forth in the Commitment) or to matters shown on the Survey (collectively, "Title & Survey Objections"), Buyer shall give Seller written notice of the same on or before the expiration of the Inspection Period. Any matters set forth in the Commitment or shown on the Survey not objected to prior to the end of the Inspection Period, or which Seller has not agreed to cure pursuant to subsection (b) and (c) below, shall be deemed "Permitted Exceptions".

(b) Seller shall have five (5) days after receipt of Buyer's Title & Survey Objections in which to respond to Buyer's Title & Survey Objections and either agree or disagree to cure the objections set forth therein. If Seller fails to respond to Buyer's Title & Survey Objections within such time period, Seller shall be deemed to have elected not to cure any of Buyer's objections as set forth in Buyer's Title & Survey Objections. Seller shall have until Closing to cure all objections that Seller has agreed to cure, at Seller's sole cost and expense. If Seller has elected or is deemed to have elected not to cure any or all of Buyer's objections as set forth in Buyer's Title & Survey Objections then, within 5 days of Buyer's receipt of Seller's response to Buyer's Title & Survey Objections (or, in the event Seller fails to respond to Buyer's Title & Survey Objections, then within 5 days of the date Seller's response to Buyer's Title & Survey Objections was due), Buyer may either (i) elect to take title to the Property subject to such title objections, whereupon all such title objections shall be deemed Permitted Exceptions, or (ii) elect to terminate this Agreement, upon such occurrence all Earnest Money shall be returned to Buyer and neither Buyer nor Seller shall have any further obligations hereunder except those that survive termination. If Buyer does not provide Seller written notice of Buyer's election as above provided, then Buyer shall be deemed to have waived such objections as

provided in the aforesaid item (i). In the event Seller cannot, using good faith efforts, prior to Closing cure one or more objections it previously elected to cure, then Buyer may (i) at Closing, cure any objections that constitute monetary liens, offsetting the cost of such cure against the Purchase Price, (ii) take title to the Property despite the existence of the uncured title objections, whereupon all such uncured title objections shall be deemed Permitted Exceptions, or (iii) terminate this Agreement, upon which such occurrence all Earnest Money shall be returned to Buyer and neither Buyer nor Seller shall have any further obligations hereunder except those that survive termination.

(c) Buyer may re-examine title up to Closing and give written notice to Seller of any objections that Buyer may have as to matters first appearing of record subsequent to the Commitment, which new objections shall be addressed as set forth above.

6. **Due Diligence Materials**. Within five (5) business days following the Effective Date, Seller shall deliver to Buyer a copy of (i) its most recent title insurance policy (including all underlying documents), (ii) any existing environmental surveys, land surveys, appraisals, topographical studies, and site plans, (iii) all material related to sewer for the property, including without limitation, Seller's grading and utility plans, and (iv) all encumbrances of record affecting the Property (the "Seller's Documents").

7. **Representations and Warranties**. As of the Effective Date and the Closing, Seller represents and warrants to Buyer that: (i) Seller has all power and authority required for it to enter into this Agreement and perform its obligations hereunder; (ii) Seller's execution and performance of this Agreement does not conflict with or violate any governmental order, judgment, writ, enactment or decree or any contract, agreement or other instrument; (iii) there are no pending or threatened lawsuits or similar proceedings that could have an adverse effect on the Property or Seller's ability to perform its obligations hereunder; (iv) there are no pending or threatened governmental actions or proceedings (including, but not limited to, eminent domain proceedings, zoning changes, plans to modify adjacent roads, reroute traffic or close a curb cut, or proposed assessments) that will affect the Property; (v) Seller has good and marketable fee simple absolute title to the Property; (vi) there are no tenants or occupants of the Property; (vii) there are no leases, licenses or other occupancy agreements encumbering the Property; (viii) no hazardous substances have been discharged, released, disposed of, incorporated into or allowed to escape on the Property by Seller or others, at Seller's direction, or, to Seller's actual knowledge, by any other person or entity; (ix) there are no cemeteries, burial grounds, matters of archeological significance, protected flora or fauna, special flood hazard areas (as defined by FEMA), flood prone areas, sinkholes, or wetlands on the Property; (x) no portion of the Property has been used as a junkyard or dump, no fill material (soil, gravel or other) has been placed on Property, and no debris (organic or inorganic) has been buried on the Property; (xi) there are no material inaccuracies or omissions in the information regarding the Property that Seller has furnished to Buyer; and (xii) Seller is not aware of any fact, event or circumstance that could have a material adverse affect on the Property. The representations and warranties set forth in this section shall survive the Closing and the delivery of any deed conveying the Property to Buyer for a period of one (1) year.

8. **Monetary Liens**. At or prior to Closing, Seller shall cause all liens, monetary judgments, mortgages, deeds of trust, deeds to secure debt, security interests and other similar encumbrances affecting the Property (collectively "Monetary Liens") to be released and discharged. In the event Seller fails to cause all Monetary Liens to be released and discharged by Closing, Buyer may, in addition to any of the other remedies available hereunder, at law or in equity, take all actions necessary to cause such Monetary Liens to be released and discharged and offset the cost thereof against the Purchase Price.

9. **Management and Cooperation**. Between the Effective Date and the Closing, Seller shall not (i) cause or permit any waste or damage to occur to the Property, (ii) make any changes, alterations or additions to the Property, or (iii) enter into any covenant, condition, restriction, easement, lease or other agreement which affects or could affect the Property. Seller covenants and agrees to cooperate with, assist and join in Buyer's efforts to obtain permits, licenses, variances, zoning changes, and other governmental consents that Buyer deems necessary or desirable for its use or development of the Property.

10. **Conditions to Closing**. Buyer's obligation to purchase the Property from Seller is contingent upon all of the following conditions being satisfied at the time the Closing is scheduled to occur:

(i) Each representation and warranty made by Seller herein being true and accurate as of the Effective Date and as of the Closing, and Seller not having defaulted under or breached any of the terms of this Agreement;

(ii) Buyer obtaining a revised copy of the Commitment (the "Updated Commitment") that (A) has been updated to Closing, (B) commits to insure that Buyer has a good and marketable fee simple absolute estate in the Property, (C) contains no requirements that must be satisfied before a title insurance policy will be issued based thereon, (D) is free of the standard exceptions, (E) contains no new exceptions, and (F) contains any endorsements reasonably requested by Buyer;

(iii) No material or adverse change occurring in the physical condition of Property, the environmental condition of the Property, or title to the Property between the Effective Date and the Closing;

(iv) No lawsuit or similar proceeding that is adverse to the Property, or Buyer's intended use thereof, having been instituted or threatened, and no law, rule, regulation, code, zoning change, tax, ordinance, investigation or other action that is adverse to the Property, or Buyer's intended use thereof, having been adopted or proposed by any governmental authority; and

(v) Buyer's obtaining all necessary governmental permits, including curb cuts and Approvals required pursuant to Section 15.

If any of the other conditions set forth above are not satisfied as of the time the Closing is scheduled to take place, Buyer may, at its sole option and in addition to any other remedies available hereunder or at law or in equity, terminate this Agreement by giving written notice to

Seller and receive a return of the Earnest Money, postpone the Closing for thirty (30) days to allow such conditions to be satisfied, or waive the unsatisfied condition; provided the provisions of this section shall continue to apply if the Closing is postponed pursuant hereto and no waiver of such conditions shall be deemed to have been made unless expressly set forth in a writing signed by Buyer.

11. **Closing**. Subject to the other terms of this Agreement, the Closing shall occur within sixty (60) days following the expiration of the Inspection Period, subject to satisfaction of the conditions of Closing specified in Section 10 (the "Closing Date"). The Closing shall take place in escrow through the Title Company. Not withstanding the foregoing, Buyer may extend the Closing Date for up to three (3) additional periods of thirty (30) days each upon deposit with the Title Company at the time of each extension payments in the amount of Ten Thousand and 00/100 Dollars ($10,000.00) for each extension, which extension deposits shall be non-refundable but shall be applied towards the Purchase Price at Closing. At the Closing, Buyer's attorney shall prepare and Seller shall deliver the following items to Buyer, properly executed and notarized and in form and substance acceptable to Buyer:

(a) A special or limited warranty deed conveying a good and marketable fee simple absolute estate in the Property to Buyer, containing the legal description of the Property as shown on the Survey, together with (A) all rights, easements, interests, privileges, tenements and hereditaments appurtenant to the Property, and (B) all of Seller's right, title and interest, whether now or hereafter acquired, in the land lying beneath the roads, streets, highways, avenues and alleys adjoining the Property. The Property shall be conveyed to Buyer subject only to the matters shown in the Commitment to which Buyer does not object, or matters to which Buyer has initially objected but subsequently waived such objection.

(b) Recorded or recordable releases terminating and releasing all Monetary Liens.

(c) An owner's affidavit for purposes of having the exceptions for mechanics' and materialmen's liens, the rights of parties in possession and unrecorded matters deleted from the Updated Commitment, and any other documents, certificates and indemnity agreements that the title company requires to issue the Updated Commitment.

(d) All other documents reasonably requested by Buyer to carry out the transaction contemplated by this Agreement, including, but not limited to, an IRS §1445 Certificate, which certifies that Seller is not a foreign person for U.S. income tax purposes.

12. **Closing Costs and Prorations**. Each of the parties shall pay its own attorneys' fees incurred in connection with the Closing contemplated by this Agreement. Buyer shall pay all escrow fees, cost of the Commitment, any loan policy premium or endorsements, the costs associated with Buyer's due diligence and inspection activities, and the cost of any mortgage taxes, if any in excess of the deed tax and transfer tax. Upon Closing, the payment of assessments (general and special, public and private) and real property taxes levied against the Property shall be the responsibility of Buyer effective January 1, 2017 and Seller shall be responsible for all taxes accrued prior to January 1, 2017 including any delinquent taxes and any "roll back" taxes.

13. **Default**.

(a) **Buyer's Default**. If Buyer fails to purchase the Property from Seller in breach of this Agreement, and without fault on the part of Seller, and does not cure such failure within ten (10) business days after receiving written notice of the same from Seller, then Seller may, as its sole and exclusive remedy, terminate this Agreement and receive the Earnest Money as full and agreed upon liquidated damages. SELLER AGREES THAT SAID LIQUIDATED DAMAGES ARE REASONABLE GIVEN EXISTING CIRCUMSTANCES, INCLUDING, WITHOUT LIMITATION, THE RANGE OF HARM THAT IS FORESEEABLE AND THE ANTICIPATION THAT PROOF OF DAMAGES WOULD BE COSTLY AND IMPRACTICAL. SELLER ACKNOWLEDGES THAT IT UNDERSTANDS THIS SECTION AND SPECIFICALLY WAIVES AND RELINQUISHES ALL OTHER REMEDIES THAT WOULD OTHERWISE BE AVAILABLE AT LAW OR EQUITY ON ACCOUNT OF BUYER'S FAILURE TO PURCHASE THE PROPERTY IN BREACH OF THIS AGREEMENT.

(b) **Seller's Default**. In the event the sale contracted for herein is not consummated due to default on the part of the Seller, then the Buyer may, in addition to all other remedies available at law and equity, elect to (i) terminate this Agreement and receive a return of the Earnest Money, or (ii) seek specific performance of this Agreement.

14. **Condemnation**. If there is an actual or threatened taking of all or any portion of the Property by eminent domain prior to Closing, then Buyer may, at its option, (i) terminate this Agreement by written notice to Seller and receive a return of the Earnest Money, or (ii) proceed with the Closing without a reduction in the Purchase Price, in which case Buyer shall have the right to control all matters related to such taking (including, but not limited to, the negotiation, contest and settlement of condemnations awards) and, at Closing, Seller shall tender to Buyer all awards which it has received on account of such taking and assign to Buyer all of Seller's right, title and interest in and to any unpaid awards payable on account of such taking. If such assignment is prohibited or would impair recovery, then, in lieu thereof, Seller shall tender to Buyer all amounts paid on account of such taking as soon as it receives the same. Seller covenants and agrees to provide prompt notice to Buyer of any notice of actual or threatened taking of all or any portion of the Property. The provisions of this Section 14 regarding Seller's obligation to tender insurance and condemnation awards to Buyer shall, if applicable, survive the Closing and the delivery of the deed conveying the Property to Buyer.

15. **Zoning, Permits and Approvals**. Buyer intends to obtain all authorizations and permits, including, without limitation, for curb cut(s) (any such applications for curb cuts shall be at Buyer's expense), signs, lot split, lot combination, re-platting of the Property, building and renovation approvals, permits, zoning and subdivision interpretations and confirmations, and all variances, set-backs, utility permits, water rights for both the Property and such other real property as is necessary to facilitate the development of the Property (as determined by Buyer in its sole discretion), authorizations and easements necessary for Buyer's intended use of the Property, approval of any existing declaration, covenants or other burdens or encumbrances affecting the development or use of the Property (collectively, the "Approvals"). Seller shall, upon request by Buyer, execute any and all documentation in support of such application for said

Approvals. If Buyer has not received or is denied or refused any such Approvals necessary to assure Buyer that the Property is suitable for Buyer's intended use of the Property, as determined in Buyer's sole and absolute discretion, or if the necessary Approvals are granted subject to any conditions that Buyer deems unacceptable in its sole and absolute discretion on or before such date, or if adequate utilities and related facilities, including, without limitation, water, stormwater and sanitary sewage disposal, telephone service and energy sources to service the Property and improvements thereto for Buyer's intended use and/or easements therefor are not available to the satisfaction of Buyer, then Buyer may, by furnishing written notice to Seller and Title Company, terminate this Agreement without owing any liability to Seller, and receive a return of the Earnest Money.

If subdivision, lot splitting, lot combination or replatting of the Property is required by any applicable governmental authority as a part of the permitting process or Approvals or as is necessary for Buyer to develop and use the Property (in Buyer's sole discretion), then Seller shall cooperate with the subdivision, lot splitting, lot combination or re-platting required at Buyer's expense. Seller agrees to execute any documents reasonably required and to support Buyer's efforts to procure any necessary site plan approvals or zoning changes or re-subdivisions or any other governmental or quasi-governmental approvals to allow for Buyer's development of the Project. Buyer acknowledges and agrees that any rezoning shall not be required to be effectuated prior to Closing.

16. **Notices**. All notices, consents and other communications (collectively, "Notices") which may be or are required to be given by Seller or Buyer hereunder shall be properly given only if made in writing and sent to the address set forth below by hand delivery, U.S. Certified Mail (Return Receipt Requested), or nationally recognized overnight delivery service. Such Notices shall be deemed received, (i) if delivered by hand, on the date of delivery, or (ii) if sent by U.S. Mail or overnight delivery service, on the date the same is deposited with the applicable carrier.

For Seller: P.F. Holdings, Inc.
Attn: Paul Fisher & Nick Nicola
365 Mulberry St.
Selmer, TN 38375

For Buyer: Capital Growth Medvest, LLC
Attn: Joe Baugh & Chad Post
361 Summit Boulevard, Suite 220
Birmingham, Alabama 35243

Either party may change its address for Notices by giving written notice to the other party in accordance with this provision. Notices may be given by Seller, Buyer, or their respective counsel.

17. **Broker**. Buyer and Seller each represents and warrants that neither party has engaged or dealt with any broker, brokerage firm, listing agent or finder in connection with the transaction contemplated by this Agreement. Buyer agrees to indemnify, defend and hold

harmless Seller from and against all suits, actions, costs, damages, liabilities and expenses (including, but not limited to, reasonable attorneys' fees, litigation expenses and court costs) arising out of any claim for a commission, fee or other compensation made by a broker with whom it has dealt. Seller agrees to indemnify, defend and hold harmless Buyer from and against all suits, actions, costs, damages, liabilities and expenses (including, but not limited to, reasonable attorneys' fees, litigation expenses and court costs) arising out of any claim for a commission, fee or other compensation made by a broker with whom it has dealt, The provisions of this section shall survive the termination of this Agreement.

18. **Construction of Agreement**. Each of the parties hereto has agreed to the use of the particular language of this Agreement, and any question regarding the meaning of this Agreement shall not be resolved by any rule providing for construction against the party who caused the uncertainty to exist or against the draftsman. No provision granting Buyer the right to terminate this Agreement shall be construed to limit the remedies available to Buyer as a result of Seller's default under or breach of the terms hereof. This Agreement (i) constitutes the entire agreement and understanding of Buyer and Seller with respect to the subject matter hereof and supersedes all prior agreements, understandings, letters, negotiations and discussions, whether oral or written, of the parties, and (ii) may be amended only by a written instrument executed by Buyer and Seller. In the event any provision hereof shall be prohibited by or invalidated under applicable law, the remaining provisions of this Agreement shall remain fully effective. No waiver of any provision of this Agreement shall be deemed to have been made unless expressed in writing and signed by the party charged therewith. No delay or omission in the exercise of any remedy accruing upon the breach of this Agreement shall impair such remedy or be construed as a waiver of such breach. The waiver by Seller or Buyer of any breach shall not be deemed a waiver of any other breach of the same or any other provision hereof. The captions and headings contained herein are for convenience and reference only, and they shall not be deemed to define, modify or add to the meaning of any provision of this Agreement. This Agreement shall be binding upon, and inure to the benefit of, the parties hereto and their respective successors and assigns. Buyer may freely assign this Agreement without prior consent of Seller; provided no such assignment shall result in Buyer being released from its obligations and liabilities hereunder. If any date specified in this Agreement for the performance of an obligation, the giving of a notice, or the expiration of a time period falls on a Saturday, Sunday, or bank holiday, then this Agreement shall be automatically revised so that such date falls on the next occurring business day. FOR PURPOSES OF THIS AGREEMENT, TIME SHALL BE CONSIDERED OF THE ESSENCE. This Agreement shall be governed by and construed under the laws of the State of Tennessee.

19. **Attorneys' Fees**. If any legal proceeding is commenced related to this Agreement, the prevailing party in such legal proceeding shall be entitled to recover its reasonable attorneys' fees, court costs and litigation expenses from the non-prevailing party therein.

20. **Waiver of Jury Trial**. SELLER AND BUYER HEREBY EXPRESSLY WAIVE THEIR RIGHT TO A TRIAL BY JURY OF ANY CLAIM (I) ARISING UNDER THIS AGREEMENT, OR (II) RELATED TO THE TRANSACTION CONTEMPLATED BY THIS AGREEMENT, WHETHER NOW EXISTING OR HEREAFTER ARISING. SELLER OR

BUYER MAY FILE AN ORIGINAL OR A COPY OF THIS SECTION WITH ANY COURT AS WRITTEN EVIDENCE OF THE FOREGOING WAIVER.

21. **Exhibits**. Buyer and Seller hereby acknowledge and agree that all exhibits referenced in this Agreement are attached hereto and incorporated herein.

22. **Effective Date**. For purposes hereof, the term "Effective Date" shall mean the date the last of the parties executes this Agreement, as set forth in the signature blocks below.

23. **Counterparts and Facsimile/Portable Document Format Execution**. This Agreement may be executed and delivered, by facsimile and portable document format and/or in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument and shall become a binding Agreement when one or more of the counterparts have been signed by each of the parties and delivered to the other party.

24. **Section 1031 Exchange**. The parties acknowledge and agree that either party may consummate this transaction as part of a so-called like/kind exchange (the "Exchange") pursuant to Section 1031 of the Internal Review Code of 1986 (the "Code"), provided, that: (a) the Closing shall not be delayed or affected by reason of the Exchange, nor shall the consummation or the accomplishment of the Exchange be a condition precedent or condition subsequent to either parties' obligations under this Agreement; (b) the exchanging party shall affect the Exchange through a qualified intermediary and accommodating party shall not be required to exchange property or be required to acquire or hold title to any real estate other than the Property as contemplated hereby; (c) the accommodating party shall not be required to incur any liability or expense in connection with the Exchange; and (d) the exchanging party shall pay any additional costs that would not otherwise have been incurred by the accommodating party had the exchanging party not consummated its sale through the Exchange. The accommodating party shall not, by this Agreement, or acquiescence to the Exchange (x) have its rights under this Agreement affected or diminished in any manner or (y) be responsible for compliance with or be deemed to have warranted to the exchanging party that the Exchange, in fact, complies with Section 1031 of the Code.

25. **Survival**. The provisions of this Agreement shall survive the Closing and the delivery of the deed conveying the Property to Buyer, provided the representations and warranties set forth in Section 7 shall only survive for the period of time expressly provided therein.

[SIGNATURES APPEAR ON FOLLOWING PAGE.]

SUPPLEMENTAL #1
January 30, 2017
11:56 am

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the dates set forth below.

BUYER:

CAPITAL GROWTH MEDVEST, LLC, an Alabama limited liability company

By: _____
Name: Joseph M. Bruno
Its: Manager
Date: 1/5/2017

SELLER:

P.F. HOLDINGS, INC.

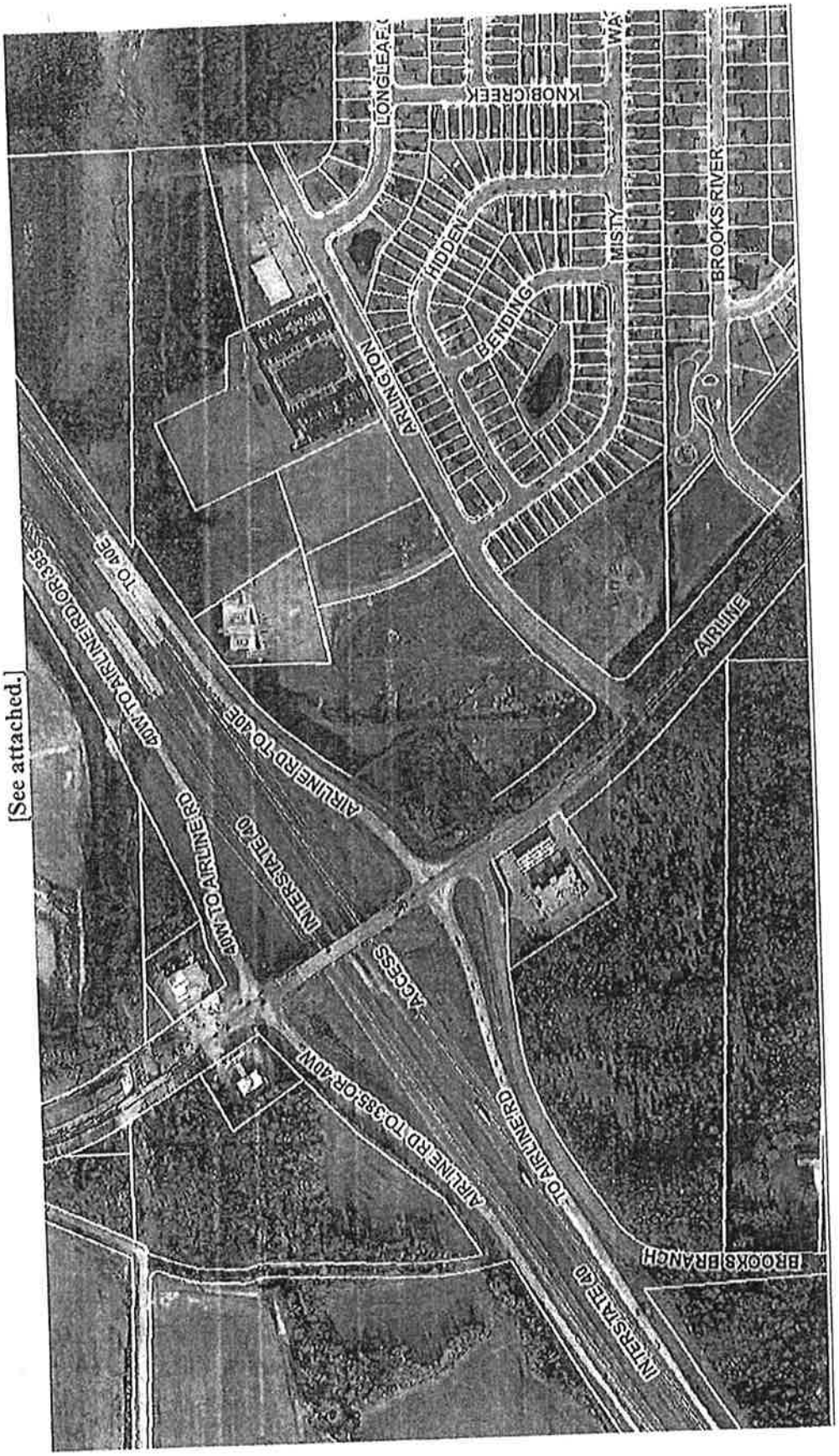
By: Paul Fisher
Name: _____
Its: _____
Date: 1-5-17

SUPPLEMENTAL #1

January 30, 2017
11:56 am

Exhibit A

[See attached.]



SUPPLEMENTAL #1
January 30, 2017
11:56 am

PURCHASE AND SALE AGREEMENT

THIS PURCHASE AND SALE AGREEMENT (this "Agreement") is made and entered into by and between **CAPITAL GROWTH MEDVEST, LLC**, an Alabama limited liability company, or its affiliate or assign ("Buyer"), and **T. DAVID GOODWIN, SR., T. DAVID GOODWIN, JR.** and **HYNEMAN HOLDINGS, LLC** (collectively, "Seller").

WITNESSETH:

For the covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Seller and Buyer agree as follows:

1. **Sale and Purchase**. Subject to and in accordance with the terms of this Agreement, Seller agrees to sell to Buyer, and Buyer agrees to purchase from Seller, certain real property located along New Airline Road in Memphis, Tennessee, containing approximately 2 acres (exact acreage to be determined by survey. Survey to be paid by Buyer. Any amount of land over 2 acres shall add to the purchase price at $7.50 per square foot. However, the minimum purchase price for the property shall be $653,400.00) being the portion of Seller's property bounding and contiguous to that certain property owned by P.F. Holdings, Inc., as depicted on **Exhibit A** attached hereto and made a part hereof, together with all improvements, rights, easements, interests, privileges, tenements and hereditaments appurtenant thereto (collectively, the "Property").

2. **Purchase Price**. At the closing and consummation of the transaction contemplated by this Agreement (the "Closing"), Buyer shall pay Seller the sum of Six Hundred Fifty-Three Thousand Four Hundred and 00/100 Dollars ($653,400.00) for the Property (the "Purchase Price"), in immediately available funds, less the amount of any credits or adjustments provided for herein.

3. **Earnest Money**. Within five (5) business days after the Effective Date (hereinafter defined in Section 23), Buyer shall deliver to Stewart Title Guaranty Company National Title Services, 5901 Peachtree Dunwoody Road, Suite A-350, Atlanta, Georgia 30328, Attention: Robert (Rob) M. Reeder (the "Title Company"), the sum of Ten Thousand and No/100 Dollars ($10,000.00), which amount, plus any interest earned thereon, is referred to as the "Earnest Money." The Earnest Money shall be credited against the Purchase Price at Closing. In the event that this Agreement shall be terminated during the Inspection Period, the Earnest Money shall be refunded in accordance with Section 4 below. At the end of the 180 day Inspection Period should the Buyer not terminate the contract, the $10,000 earnest money becomes non refundable and will be credited to the Purchase Price at closing.

4. **Inspection**.

(a) For purposes of this Agreement, the term "Inspection Period" shall mean and refer to the period commencing on the Effective Date and expiring at 11:59 p.m. central time on the date that is one hundred eighty (180) days after the the Effective Date. Buyer and Buyer's

Inspections conducted by Buyer may include, but are not limited to, evaluation of: (i) current zoning and required rezoning for intended use, (ii) soil conditions, (iii) environmental conditions, (iv) traffic impact, (v) utility availability, (vi) storm water retention, (vii) archaeological considerations, (viii) servitudes, (ix) endangered species, (x) wetlands, (xi) flood zone, (xii) buffer/setback requirements, (xiii) fire access requirements, (xiv) access, (xv) survey, (xvi) local building ordinances and restrictions, (xvi) signage rights, and any other matter Buyer deems relevant. Buyer shall indemnify, protect, defend and hold harmless Seller from and against any and all losses, claims, damages and costs (including court costs and reasonable attorneys' fees) arising out of any claims made solely in connection with Buyer's access to, entry upon, inspection and/or testing of the Property, except to the extent such claims are caused by the negligence of Seller. The discovery of hazardous materials or releases, title defects, unsafe conditions, etc., and the reporting of same and the incursion of fines or costs by Seller to remedy same shall not constitute harm to Seller.

(b) Buyer may terminate this Agreement for any reason, or for no reason, in its sole and absolute discretion, by giving written notice to Seller on or before the date and time the Inspection Period expires. In the event that this Agreement shall be terminated by Buyer during the Inspection Period, the Earnest Money shall be immediately refunded to Buyer in full.

5. Title and Survey Matters.

(a) Prior to the expiration of the Inspection Period, Buyer shall order a commitment for an ALTA Owner's Extended Coverage Policy of Title Insurance (Form 2006) from an agent of Title Company selected by Buyer, showing the status of title to the Property (the "Commitment"). At Buyer's discretion and expense, Buyer may all also order a current ALTA survey of the Property (the "Survey") certified to Buyer, Seller and the Title Company. The Commitment shall be in the amount of the Purchase Price and shall commit to insure the Buyer has good and marketable fee simple absolute title to the Property. If Buyer has any objections to the status of title to the Property (including, but not limited to, the exceptions and requirements set forth in the Commitment) or to matters shown on the Survey (collectively, "Title & Survey Objections"), Buyer shall give Seller written notice of the same on or before the expiration of the Inspection Period. Any matters set forth in the Commitment or shown on the Survey not objected to prior to the end of the Inspection Period, or which Seller has not agreed to cure pursuant to subsection (b) and (c) below, shall be deemed "Permitted Exceptions".

(b) Seller shall have five (5) days after receipt of Buyer's Title & Survey Objections in which to respond to Buyer's Title & Survey Objections and either agree or disagree to cure the objections set forth therein. If Seller fails to respond to Buyer's Title & Survey Objections within such time period, Seller shall be deemed to have elected not to cure any of Buyer's objections as set forth in Buyer's Title & Survey Objections. Seller shall have until Closing to cure all objections that Seller has agreed to cure, at Seller's sole cost and expense. If Seller has elected or is deemed to have elected not to cure any or all of Buyer's objections as set forth in Buyer's Title & Survey Objections then, within 5 days of Buyer's receipt of Seller's response to Buyer's Title & Survey Objections (or, in the event Seller fails to respond to Buyer's Title & Survey Objections, then within 5 days of the date Seller's response to Buyer's Title & Survey Objections was due), Buyer may either (i) elect to take title to the Property subject to

such title objections, whereupon all such title objections shall be deemed Permitted Exceptions, or (ii) elect to terminate this Agreement, upon such occurrence all Earnest Money shall be returned to Buyer and neither Buyer nor Seller shall have any further obligations hereunder except those that survive termination. If Buyer does not provide Seller written notice of Buyer's election as above provided, then Buyer shall be deemed to have waived such objections as provided in the aforesaid item (i). In the event Seller cannot, using good faith efforts, prior to Closing cure one or more objections it previously elected to cure, then Buyer may (i) at Closing, cure any objections that constitute monetary liens, offsetting the cost of such cure against the Purchase Price, (ii) take title to the Property despite the existence of the uncured title objections, whereupon all such uncured title objections shall be deemed Permitted Exceptions, or (iii) terminate this Agreement, upon which such occurrence all Earnest Money shall be returned to Buyer and neither Buyer nor Seller shall have any further obligations hereunder except those that survive termination.

~~(e)~~ Buyer may re-examine title up to Closing and give written notice to Seller of any objections that Buyer may have as to matters first appearing of record subsequent to the Commitment, which new objections shall be addressed as set forth above.

6. Intentionally Omitted.

7. **Representations and Warranties**. As of the Effective Date and the Closing, Seller represents and warrants to Buyer that: (i) Seller has all power and authority required for it to enter into this Agreement and perform its obligations hereunder; (ii) Seller's execution and performance of this Agreement does not conflict with or violate any governmental order, judgment, writ, enactment or decree or any contract, agreement or other instrument; (iii) there are no pending or threatened lawsuits or similar proceedings that could have an adverse effect on the Property or Seller's ability to perform its obligations hereunder; (iv) there are no pending or threatened governmental actions or proceedings (including, but not limited to, eminent domain proceedings, zoning changes, plans to modify adjacent roads, reroute traffic or close a curb cut, or proposed assessments) that will affect the Property; (v) Seller has good and marketable fee simple absolute title to the Property; (vi) there are no tenants or occupants of the Property; (vii) there are no leases, licenses or other occupancy agreements encumbering the Property; (viii) no hazardous substances have been discharged, released, disposed of, incorporated into or allowed to escape on the Property by Seller or others, at Seller's direction, or, to Seller's actual knowledge, by any other person or entity; (ix) To the best of Seller's knowledge, there are no cemeteries, burial grounds, matters of archeological significance, protected flora or fauna, special flood hazard areas (as defined by FEMA), flood prone areas, sinkholes, or wetlands on the Property; (x) no portion of the Property has been used as a junkyard or dump, no fill material (soil, gravel or other) has been placed on Property, and no debris (organic or inorganic) has been buried on the Property; (xi) there are no material inaccuracies or omissions in the information regarding the Property that Seller has furnished to Buyer; and (xii) Seller is not aware of any fact, event or circumstance that could have a material adverse affect on the Property. The representations and warranties set forth in this section shall survive the Closing and the delivery of any deed conveying the Property to Buyer for a period of one (1) year.

8. Monetary Liens. At or prior to Closing, Seller shall cause all liens, monetary judgments, mortgages, deeds of trust, deeds to secure debt, security interests and other similar encumbrances affecting the Property (collectively "Monetary Liens") to be released and discharged. In the event Seller fails to cause all Monetary Liens to be released and discharged by Closing, Buyer may, in addition to any of the other remedies available hereunder, at law or in equity, take all actions necessary to cause such Monetary Liens to be released and discharged and offset the cost thereof against the Purchase Price.

9. Management and Cooperation. Between the Effective Date and the Closing, Seller shall not (i) cause or permit any waste or damage to occur to the Property, (ii) make any changes, alterations or additions to the Property, or (iii) enter into any covenant, condition, restriction, easement, lease or other agreement which affects or could affect the Property. Seller covenants and agrees to cooperate with, assist and join in Buyer's efforts to obtain permits, licenses, variances, zoning changes, and other governmental consents that Buyer deems necessary or desirable for its use or development of the Property.

10. Conditions to Closing. Buyer's obligation to purchase the Property from Seller is contingent upon all of the following conditions being satisfied at the time the Closing is scheduled to occur:

(i) Each representation and warranty made by Seller herein being true and accurate as of the Effective Date and as of the Closing, and Seller not having defaulted under or breached any of the terms of this Agreement;

(ii) Buyer obtaining a revised copy of the Commitment (the "Updated Commitment") that (A) has been updated to Closing, (B) commits to insure that Buyer has a good and marketable fee simple absolute estate in the Property, (C) contains no requirements that must be satisfied before a title insurance policy will be issued based thereon, (D) is free of the standard exceptions, (E) contains no new exceptions, and (F) contains any endorsements reasonably requested by Buyer;

(iii) No material or adverse change occurring in the physical condition of Property, the environmental condition of the Property, or title to the Property between the Effective Date and the Closing;

(iv) No lawsuit or similar proceeding that is adverse to the Property, or Buyer's intended use thereof, having been instituted or threatened, and no law, rule, regulation, code, zoning change, tax, ordinance, investigation or other action that is adverse to the Property, or Buyer's intended use thereof, having been adopted or proposed by any governmental authority; and

(v) Buyer's obtaining all necessary governmental permits, including curb cuts and Approvals required pursuant to Section 15.

If any of the other conditions set forth above are not satisfied as of the time the Closing is scheduled to take place, Buyer may, at its sole option and in addition to any other remedies available hereunder or at law or in equity, terminate this Agreement by giving written notice to

Seller and receive a return of the Earnest Money, postpone the Closing for thirty (30) days to allow such conditions to be satisfied, or waive the unsatisfied condition; provided the provisions of this section shall continue to apply if the Closing is postponed pursuant hereto and no waiver of such conditions shall be deemed to have been made unless expressly set forth in a writing signed by Buyer.

11. **Closing**. Subject to the other terms of this Agreement, the Closing shall occur within sixty (60) days following the expiration of the Inspection Period, subject to satisfaction of the conditions of Closing specified in Section 10 (the "Closing Date"). The Closing shall take place in escrow through the Title Company. At the Closing, Buyer's attorney shall prepare and Seller shall deliver the following items to Buyer, properly executed and notarized and in form and substance acceptable to Buyer. Notwithstanding the foregoing, Buyer may extend the Closing Date for up to two (2) additional periods of thirty (30) days each upon deposit with the Title Company at the time each such extension is requested of extension payments in the amount of Ten Thousand and 00/100 Dollars ($10,000.00) for the each extension, which extension deposits shall be non-refundable but shall be applied towards the Purchase Price at Closing.

(a) A special or limited warranty deed conveying a good and marketable fee simple absolute estate in the Property to Buyer, containing the legal description of the Property as shown on the Survey, together with (A) all rights, easements, interests, privileges, tenements and hereditaments appurtenant to the Property, and (B) all of Seller's right, title and interest, whether now or hereafter acquired, in the land lying beneath the roads, streets, highways, avenues and alleys adjoining the Property. The Property shall be conveyed to Buyer subject only to the matters shown in the Commitment to which Buyer does not object, or matters to which Buyer has initially objected but subsequently waived such objection.

(b) Recorded or recordable releases terminating and releasing all Monetary Liens.

(c) An owner's affidavit for purposes of having the exceptions for mechanics' and materialmen's liens, the rights of parties in possession and unrecorded matters deleted from the Updated Commitment, and any other documents, certificates and indemnity agreements that the title company requires to issue the Updated Commitment.

(d) All other documents reasonably requested by Buyer to carry out the transaction contemplated by this Agreement, including, but not limited to, an IRS §1445 Certificate, which certifies that Seller is not a foreign person for U.S. income tax purposes.

12. **Closing Costs and Prorations**. Each of the parties shall pay any attorneys' fees that it incurs in connection with the transaction contemplated by this Agreement. Buyer shall pay escrow fees, cost of the Commitment, any loan policy premium or endorsements, the costs associated with Buyer's due diligence and inspection activities, and the cost of any mortgage taxes, if any in excess of the deed tax and transfer tax. Buyer shall pay escrow fees, the deed tax, transfer tax and recording fees, owner's title policy premium, and Seller shall pay any charges incurred in connection with clearing title, including without limitation, any prepayment or release fees. The payment of assessments (general and special, public and private) and real property taxes levied against the Property shall be prorated at Closing on a calendar year basis.

Seller shall be responsible for all taxes owed for the period prior to Closing, including any delinquent taxes and any "roll back" taxes.

13. **Default**.

(a) **Buyer's Default**. If Buyer fails to purchase the Property from Seller in breach of this Agreement, and without fault on the part of Seller, and does not cure such failure within ten (10) business days after receiving written notice of the same from Seller, then Seller may, as its sole and exclusive remedy, terminate this Agreement and receive the Earnest Money as full and agreed upon liquidated damages. SELLER AGREES THAT SAID LIQUIDATED DAMAGES ARE REASONABLE GIVEN EXISTING CIRCUMSTANCES, INCLUDING, WITHOUT LIMITATION, THE RANGE OF HARM THAT IS FORESEEABLE AND THE ANTICIPATION THAT PROOF OF DAMAGES WOULD BE COSTLY AND IMPRACTICAL. SELLER ACKNOWLEDGES THAT IT UNDERSTANDS THIS SECTION AND SPECIFICALLY WAIVES AND RELINQUISHES ALL OTHER REMEDIES THAT WOULD OTHERWISE BE AVAILABLE AT LAW OR EQUITY ON ACCOUNT OF BUYER'S FAILURE TO PURCHASE THE PROPERTY IN BREACH OF THIS AGREEMENT.

(b) **Seller's Default**. In the event the sale contracted for herein is not consummated due to default on the part of the Seller, then the Buyer may, in addition to all other remedies available at law and equity, elect to (i) terminate this Agreement and receive a return of the Earnest Money, or (ii) seek specific performance of this Agreement. In the event that Buyer elects to terminate this Agreement pursuant to this Section 13(b), in addition to the return of the Earnest Money, Seller shall be obligated upon demand to reimburse Buyer for Buyer's actual reasonable, third-party, out-of-pocket costs incurred in connection with the transaction. Seller's obligations under this Section 13(b) shall survive the termination of this Agreement.

14. **Condemnation**. If there is an actual or threatened taking of all or any portion of the Property by eminent domain prior to Closing, then Buyer may, at its option, (i) terminate this Agreement by written notice to Seller and receive a return of the Earnest Money, or (ii) proceed with the Closing without a reduction in the Purchase Price, in which case Buyer shall have the right to control all matters related to such taking (including, but not limited to, the negotiation, contest and settlement of condemnations awards) and, at Closing, Seller shall tender to Buyer all awards which it has received on account of such taking and assign to Buyer all of Seller's right, title and interest in and to any unpaid awards payable on account of such taking. If such assignment is prohibited or would impair recovery, then, in lieu thereof, Seller shall tender to Buyer all amounts paid on account of such taking as soon as it receives the same. Seller covenants and agrees to provide prompt notice to Buyer of any notice of actual or threatened taking of all or any portion of the Property. The provisions of this Section 14 regarding Seller's obligation to tender insurance and condemnation awards to Buyer shall, if applicable, survive the Closing and the delivery of the deed conveying the Property to Buyer.

15. **Zoning, Permits and Approvals**. Buyer intends at Buyer's expense to obtain all authorizations and permits, including, without limitation, for curb cut(s) (any such applications for curb cuts shall be at Buyer's expense), signs, lot split, lot combination, re-platting of the Property, building and renovation approvals, permits, zoning and subdivision interpretations and

confirmations, and all variances, set-backs, utility permits, water rights for both the Property and such other real property as is necessary to facilitate the development of the Property (as determined by Buyer in its sole discretion), authorizations and easements necessary for Buyer's intended use of the Property, approval of any existing declaration, covenants or other burdens or encumbrances affecting the development or use of the Property (collectively, the "Approvals"). Seller shall, upon request by Buyer, execute any and all documentation in support of such application for said Approvals. If Buyer has not received or is denied or refused any such Approvals necessary to assure Buyer that the Property is suitable for Buyer's intended use of the Property, as determined in Buyer's sole and absolute discretion, or if the necessary Approvals are granted subject to any conditions that Buyer deems unacceptable in its sole and absolute discretion on or before such date, or if adequate utilities and related facilities, including, without limitation, water, stormwater and sanitary sewage disposal, telephone service and energy sources to service the Property and improvements thereto for Buyer's intended use and/or easements therefor are not available to the satisfaction of Buyer, then Buyer may, by furnishing written notice to Seller and Title Company, terminate this Agreement without owing any liability to Seller, and receive a return of the Earnest Money.

If subdivision, lot splitting, lot combination or replatting of the Property is required by any applicable governmental authority as a part of the permitting process or Approvals or as is necessary for Buyer to develop and use the Property (in Buyer's sole discretion), then Seller shall cooperate with the subdivision, lot splitting, lot combination or re-platting required at Buyer's expense. Seller agrees to execute any documents reasonably required and to support Buyer's efforts to procure any necessary site plan approvals or zoning changes or re-subdivisions or any other governmental or quasi-governmental approvals to allow for Buyer's development of the Project. Buyer acknowledges and agrees that any rezoning shall not be required to be effectuated prior to Closing.

16. **Notices**. All notices, consents and other communications (collectively, "Notices") which may be or are required to be given by Seller or Buyer hereunder shall be properly given only if made in writing and sent to the address set forth below by hand delivery, U.S. Certified Mail (Return Receipt Requested), or nationally recognized overnight delivery service. Such Notices shall be deemed received, (i) if delivered by hand, on the date of delivery, or (ii) if sent by U.S. Mail or overnight delivery service, on the date the same is deposited with the applicable carrier.

For Seller:
T. David Goodwin, Jr.
214 Ridgefield Road
Memphis, Tennessee 38111
(901) 289-4241

For Buyer:
Capital Growth Medvest, LLC
Attn: Joe Baugh & Chad Post
361 Summit Boulevard, Suite 220
Birmingham, Alabama 35243

Either party may change its address for Notices by giving written notice to the other party in accordance with this provision. Notices may be given by Seller, Buyer, or their respective counsel.

17. **Broker**. Buyer and Seller each represents and warrants that neither party has engaged or dealt with any broker, brokerage firm, listing agent or finder in connection with the transaction contemplated by this Agreement, except that Capital Growth Real Estate, LLC, represents the Buyer ("Buyer's Broker") and T. David Goodwin, Jr. represents the Seller (Seller's Broker). Seller agrees to pay the Buyer's Broker and Seller's Broker each a commission of three percent (3%) of the Purchase Price at Closing. Buyer agrees to indemnify, defend and hold harmless Seller from and against all suits, actions, costs, damages, liabilities and expenses (including, but not limited to, reasonable attorneys' fees, litigation expenses and court costs) arising out of any claim for a commission, fee or other compensation made by a broker with whom it has dealt. Seller agrees to indemnify, defend and hold harmless Buyer from and against all suits, actions, costs, damages, liabilities and expenses (including, but not limited to, reasonable attorneys' fees, litigation expenses and court costs) arising out of any claim for a commission, fee or other compensation made by a broker with whom it has dealt, other than Buyer's Broker. The provisions of this section shall survive the termination of this Agreement.

18. **Construction of Agreement**. Each of the parties hereto has agreed to the use of the particular language of this Agreement, and any question regarding the meaning of this Agreement shall not be resolved by any rule providing for construction against the party who caused the uncertainty to exist or against the draftsman. No provision granting Buyer the right to terminate this Agreement shall be construed to limit the remedies available to Buyer as a result of Seller's default under or breach of the terms hereof. This Agreement (i) constitutes the entire agreement and understanding of Buyer and Seller with respect to the subject matter hereof and supersedes all prior agreements, understandings, letters, negotiations and discussions, whether oral or written, of the parties, and (ii) may be amended only by a written instrument executed by Buyer and Seller. In the event any provision hereof shall be prohibited by or invalidated under applicable law, the remaining provisions of this Agreement shall remain fully effective. No waiver of any provision of this Agreement shall be deemed to have been made unless expressed in writing and signed by the party charged therewith. No delay or omission in the exercise of any remedy accruing upon the breach of this Agreement shall impair such remedy or be construed as a waiver of such breach. The waiver by Seller or Buyer of any breach shall not be deemed a waiver of any other breach of the same or any other provision hereof. The captions and headings contained herein are for convenience and reference only, and they shall not be deemed to define, modify or add to the meaning of any provision of this Agreement. This Agreement shall be binding upon, and inure to the benefit of, the parties hereto and their respective successors and assigns. Buyer may freely assign this Agreement without prior consent of Seller; provided no such assignment shall result in Buyer being released from its obligations and liabilities hereunder. If any date specified in this Agreement for the performance of an obligation, the giving of a notice, or the expiration of a time period falls on a Saturday, Sunday, or bank holiday, then this Agreement shall be automatically revised so that such date falls on the next occurring business day. FOR PURPOSES OF THIS AGREEMENT, TIME SHALL BE CONSIDERED OF THE ESSENCE. This Agreement shall be governed by and construed under the laws of the State of Tennessee.

19. **Attorneys' Fees**. If any legal proceeding is commenced related to this Agreement, the prevailing party in such legal proceeding shall be entitled to recover its reasonable attorneys' fees, court costs and litigation expenses from the non-prevailing party therein.

20. **Waiver of Jury Trial**. SELLER AND BUYER HEREBY EXPRESSLY WAIVE THEIR RIGHT TO A TRIAL BY JURY OF ANY CLAIM (I) ARISING UNDER THIS AGREEMENT, OR (II) RELATED TO THE TRANSACTION CONTEMPLATED BY THIS AGREEMENT, WHETHER NOW EXISTING OR HEREAFTER ARISING. SELLER OR BUYER MAY FILE AN ORIGINAL OR A COPY OF THIS SECTION WITH ANY COURT AS WRITTEN EVIDENCE OF THE FOREGOING WAIVER.

21. **Exhibits**. Buyer and Seller hereby acknowledge and agree that all exhibits referenced in this Agreement are attached hereto and incorporated herein.

22. **Effective Date**. For purposes hereof, the term "Effective Date" shall mean the date the last of the parties executes this Agreement, as set forth in the signature blocks below.

23. **Counterparts and Facsimile/Portable Document Format Execution**. This Agreement may be executed and delivered, by facsimile and portable document format and/or in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument and shall become a binding Agreement when one or more of the counterparts have been signed by each of the parties and delivered to the other party.

24. **Section 1031 Exchange**. The parties acknowledge and agree that either party may consummate this transaction as part of a so-called like/kind exchange (the "Exchange") pursuant to Section 1031 of the Internal Review Code of 1986 (the "Code"), provided, that: (a) the Closing shall not be delayed or affected by reason of the Exchange, nor shall the consummation or the accomplishment of the Exchange be a condition precedent or condition subsequent to either parties' obligations under this Agreement; (b) the exchanging party shall affect the Exchange through a qualified intermediary and accommodating party shall not be required to exchange property or be required to acquire or hold title to any real estate other than the Property as contemplated hereby; (c) the accommodating party shall not be required to incur any liability or expense in connection with the Exchange; and (d) the exchanging party shall pay any additional costs that would not otherwise have been incurred by the accommodating party had the exchanging party not consummated its sale through the Exchange. The accommodating party shall not, by this Agreement, or acquiescence to the Exchange (x) have its rights under this Agreement affected or diminished in any manner or (y) be responsible for compliance with or be deemed to have warranted to the exchanging party that the Exchange, in fact, complies with Section 1031 of the Code.

25. **Survival**. The provisions of this Agreement shall survive the Closing and the delivery of the deed conveying the Property to Buyer, provided the representations and warranties set forth in Section 6 shall only survive for the period of time expressly provided therein.

[SIGNATURES APPEAR ON FOLLOWING PAGE.]

SUPPLEMENTAL #1
January 30, 2017
11:56 am

25. **Survival**. The provisions of this Agreement shall survive the Closing and the delivery of the deed conveying the Property to Buyer, provided the representations and warranties set forth in Section 6 shall only survive for the period of time expressly provided therein.

[SIGNATURES APPEAR ON FOLLOWING PAGE.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the dates set forth below.

BUYER:

CAPITAL GROWTH MEDVEST, LLC, an Alabama limited liability company

By: _____
Name: Joseph M. Bang
Its: Manager
Date: 1/5/2017

SELLER:

HYNEMAN HOLDINGS, LLC

By: _____
Name: _____
Its: _____
Date: 01/03/17

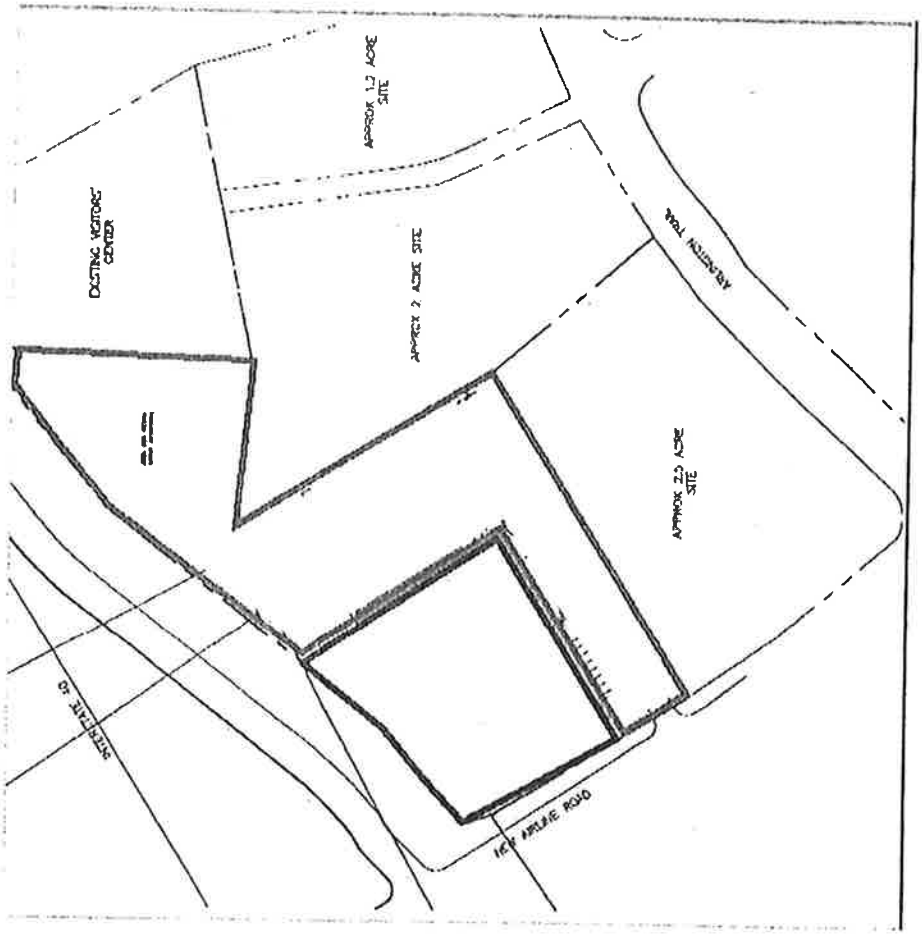
By: _____
Name: **T. DAVID GOODWIN, SR.**
Date: _____

By: _____
Name: **T. DAVID GOODWIN, JR.**
Date: _____

SUPPLEMENTAL #1

January 30, 2017
11:56 am

Exhibit A (See new exhibit showing 5.15 acres)

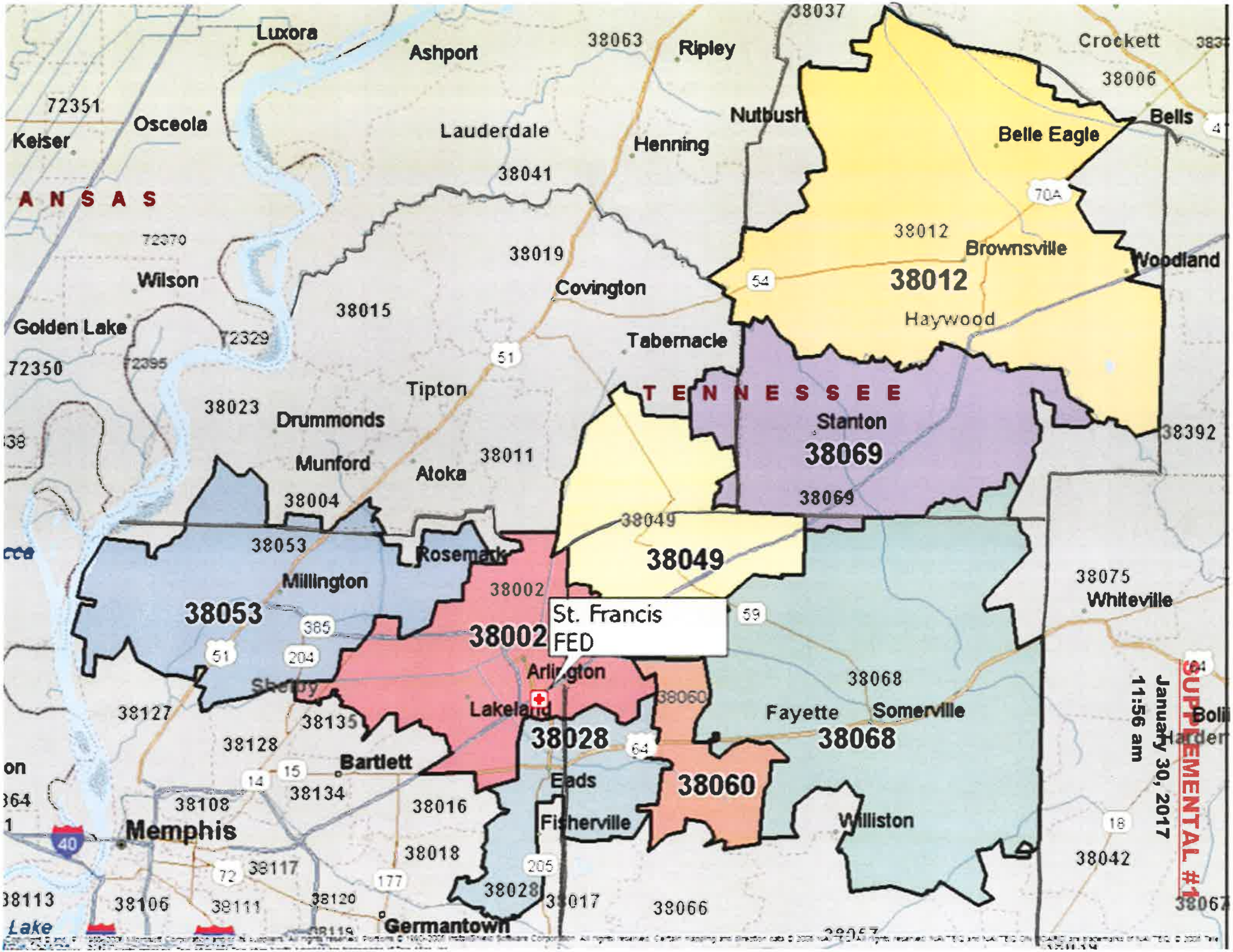


SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Need, Item 3

Revised Zip Code Service Area Map

Revised Page 17



Luxora
Ashport
38063
Ripley
38037
Crockett
38006
72351
Osceola
Keiser
Lauderdale
Nutbush
Henning
Belle Eagle
Bells
38041
A N S A S
70A
38012
Brownsville
Woodland
72370
38019
Wilson
Covington
54
38012
38015
Haywood
Golden Lake
72329
Tabernacle
72350
72395
51
Tipton
T E N N E S S E E
38023
Drummonds
Stanton
38392
38069
Munford
38011
Atoka
38004
38069
38049
38053
Rosemark
38049
Millington
38002
38075
Whiteville
38053
385
St. Francis
FED
59
38002
51
204
Arlington
38068
Sherby
38060
38127
Lakeland
Fayette
Somerville
38135
38028
38068
38128
64
Bartlett
15
14
Eads
38060
38134
38108
38016
Fisherville
Williston
Memphis
40
18
38018
38042
72
38117
205
177
38028
38113
38106
38111
38120
38017
38066
38067
Lake
Germantown
SUPPLEMENTAL #1
January 30, 2017
11:56 am

38028, 38053 and 38054 (Shelby County), 38060 and 38068 (Fayette County), 38012 and 38069 (Haywood County), and 38049 (Tipton County).

This service area is reasonable because it is based on the existing service area for emergency department visits for SFH-Bartlett. A zip code level map is included as Attachment Section C, Need-3.

Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents SFH-Bartlett	% of total procedures
Fayette	3.043	8%
Haywood	159	.4%
Tipton	2,476	6%
Shelby	34,020	86%
TOTAL	39,698	100%

Service Area Counties	Projected Utilization-County Residents SFH-Bartlett Year 1	% of total procedures
Fayette	4,060	9%
Haywood	390	1%
Tipton	2,719	6%
Shelby	36,629	84%
Total	43,798	100%

Service Area Counties	Projected Utilization-County Residents FSED Project Year 1	% of total procedures
Fayette	1,413	25%
Haywood	314	6%
Tipton	305	5%
Shelby	3,559	64%
Total	5,591	100%

Service Area Counties	Projected Utilization-County Residents FSED Project Year 2	% of total procedures
Fayette	1,760	26%
Haywood	330	5%
Tipton	355	5%
Shelby	4,211	63%
Total	6,656	100%

Response: The applicant projects utilization for the first two years of the FSED as shown above. The applicant expects that at least 20-25% of these visits will be shifted from SFH-Bartlett due to the difference in proximity for the patients to the FSED. The applicant anticipates a difference in the percentage of procedures from each county because the existing SFH-Bartlett ED sees a greater percentage of patients from Shelby County than the FSED is expected to. As the FSED is located approximately 9 miles from SFH-Bartlett, it makes sense that the patients from the Shelby County areas located in closest proximity to SFH-Bartlett will continue to receive emergency services at SFH-Bartlett because it is more convenient than the proposed FSED location. This results in a greater percentage of the patient visits coming from areas farther out from Bartlett, where patients do not currently have the convenient access to emergency services and will welcome a facility located closer to them.

Attachment Section B, Need, Item 3.(2)

Revised Page 20

SUPPLEMENTAL #1
January 30, 2017
11:56 am

A. 1) Describe the demographics of the population to be served by the proposal.

2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year 2017	Total Population-Projected Year 2021	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Fayette	45,626	49,441	8.4%	N/A	N/A	N/A	N/A	43.7	$54,890	5,351	13.9%	7,284	16%
Haywood	18,348	18,048	-1.6%	N/A	N/A	N/A	N/A	39.9	$34,182	4,107	22.8%	6,047	33%
Shelby	964,804	986,423	2.2%	N/A	N/A	N/A	N/A	34.9	$46,224	196,471	21.4%	281,655	29.2%
Tipton	68,274	72,169	5.7%	N/A	N/A	N/A	N/A	37.0	$53,669	8,292	13.6%	14,293	20.9%
Service Area Total	1,097,052	1,126,081	2.6%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	309,279	28.2%
State of TN Total	6,887,572	7,179,512	4.2%	N/A	N/A	N/A	N/A	38.4	$45,219	1,117,594	17.6%	1,559,209	22.6%
38002	41,561	43,413	4.5%	N/A	N/A	N/A	N/A	37.5	$93,603	2,345	5.0%	N/A	N/A
38012	14,763	14,785	.1%	N/A	N/A	N/A	N/A	39.9	$33,650	3,349	23.9%	N/A	N/A
38028	6,498	7,197	3.6%	N/A	N/A	N/A	N/A	48.8	$93,892	230	3.3%	N/A	N/A
38049	4,940	4,981	1%	N/A	N/A	N/A	N/A	41.5	$35,826	1,048	22.3%	N/A	N/A
38053	29,390	29,794	1.4%	N/A	N/A	N/A	N/A	40.2	$51,423	4,625	16.3%	N/A	N/A
38054	63	63	0%	N/A	N/A	N/A	N/A	24.0	$86,750	0	0.0%	N/A	N/A
38060	10,512	10,982	4.5%	N/A	N/A	N/A	N/A	37.4	$64,636	636	6.1%	N/A	N/A
38068	10,865	10,955	1%	N/A	N/A	N/A	N/A	42.5	$41,048	1,942	18.2%	N/A	N/A
38069	2,615	2,612	0%	N/A	N/A	N/A	N/A	38.0	$33,784	569	23.3%	N/A	N/A
Service Area Total	121,207	124,719	2.9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
State of TN Total	6,887,572	7,179,512	4.2%	N/A	N/A	N/A	N/A	38.4	$45,219	1,117,594	17.6%	1,559,209	22.6%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Need, Item 3.(b)

Revised Page 22

Letter to Department of Health - JAR Correction

Emergency Department Utilization
2013-2015

Hospital	Treatment Rooms	2013 Visits	2014 Visits	2015 Visits	2015 Visits/Room
SFH-Bartlett	33	36,001	38,145	42,220	1,280
Baptist Memphis	54	60,274	62,857	62,492	1,157
Regional One	51	55,963	53,187	52,327	1,026
Baptist - Collierville	13	16,714	14,690	17,219	1,325
Baptist-Tipton	13	20,363	19,367	20,954	1,612
Baptist-Women's	8	N/A	N/A	10,172	1,271
Delta Medical Center	13	26,459	23,963	25,557	1,966
Haywood Park Community Hospital	N/A	5,460	2,659	0	N/A
Methodist-LeBonheur	N/A	55,358	87,684	93,442	N/A
Methodist University	54	62,587	67,821	70,051	1,297
Methodist South	27	62,300	62,822	65,601	1,773
Methodist North	43	69,062	70,872	72,247	1,680
Methodist Germantown	38	54,914	53,817	57,468	1,512
Methodist-Fayette	N/A	7,991	7,580	1,408	N/A
SFH-Park	39	43,989	49,746	54,522	1,398

Source: Tennessee Department of Health, Joint Annual Report of Hospitals, 2013-2015.
Note: Haywood Park Community Hospital closed in 2014 and Methodist Fayette closed in 2015. The treatment rooms for Baptist Memphis are taken from the supplemental responses to its Lakeland FSED application

In 2013, SFH-Bartlett increased the number of its emergency treatment rooms from 19 to 33. SFH-Bartlett had 42,220 visits to its emergency room in 2015, or 1,280 visits per treatment room. That number represents an increase of 17% between 2013 and 2015. In 2016, that number increased to 43,644, or 1,323 per treatment room. The applicant anticipates that the number of visits per treatment room will meet or exceed 1,500 sometime in 2019. Overall, in 2015, the hospitals in Shelby and Tipton Counties had a total of 550,830 visits, 386 treatment rooms, and 1,427 visits per treatment room.

Please see table below for the distance between existing or closed facilities and the proposed FSED location. It is important to locate emergency services as close to the patient population as possible, which in this situation is primarily a rural population without viable treatment options. Generally, time to treatment can be critical. SFH-Bartlett is the closest facility at just over 9 miles. Haywood Park was the farthest away at 36 miles. The applicant anticipates drawing patients from the western portion of Haywood County, which is a straight shot to the proposed FSED. The addition of this facility will allow more convenient access to a necessary health care service for much of the rural service area population as well as allowing patients to have a choice in their health care provider for emergency services.

SUPPLEMENTAL #1

January 30, 2017

11:56 am

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Alex H. Mills
615.850.8131 direct
alex.mills@wallerlaw.com

January 27, 2017

Lonnie Matthews
Department of Health
710 James Robertson Parkway
Nashville, TN 37243

Re: Saint Francis Hospital-Bartlett: Correction to 2015 Joint Annual Report for Hospitals

Dear Mr. Matthews:

I am writing today on behalf of Saint Francis Hospital-Bartlett ("SFH-Bartlett"). It has recently come to our attention that page 38 of the 2015 Joint Annual Report for Hospitals for SFH-Bartlett incorrectly reports the number of patients treated in SFH-Bartlett's ER as 45,572. The actual number of patients treated for the year was 42,220. We wanted to make you aware of this inaccuracy and provide you with a corrected page indicating the proper number of visits for your records so that more accurate data is available.

Best regards,

alex mills

Alex H. Mills

AHM
Enclosure

SCHEDULE I - EMERGENCY DEPARTMENT (continued)* State ID 79516.

6. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	◉	○
Ambulances	◉	○
Other hospitals	◉	○
B. HELIPORT:	◉	○
C. PHARMACY IN ER:	○	◉
D. BLOOD BANK (check ONLY one):		
Fully stocked	◉	
Common blood types only	◉	

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ○ YES ◉ NO

B. Burns ○ YES ◉ NO

If yes, do you have a designation by a government agency as a Burn Center? ○ YES ◉ NO

C. Pediatrics ○ YES ◉ NO

D. Other, specify _____

8. Triage: A. Total number of patients who presented in your ER. 46,742

B. Total number treated in your ER. ~~45,572~~ 42,220

C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Economic Feasibility, Item 2

Funding Letter

SUPPLEMENTAL #1

January 30, 2017
11:56 am

Saint Francis Hospital - Bartlett

TENET
Tennessee

2986 Kate Bond Road
Bartlett, TN 38133-4003
(901) 820-7000

January 27, 2017

Melanie Hill, Executive Director
Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill,

RE: Application of Certificate of Need by Saint Francis Hospital – Bartlett for a Freestanding Emergency Department

This letter certifies that in consideration of Saint Francis Hospital – Bartlett filing the above – captioned for a Certificate of Need, Tenet Healthcare Corporation (Tenet), ultimate parent corporation of Saint Francis Hospital – Bartlett, makes the commitment to provide the necessary funding for the purpose of development of this project, which is not expected to exceed $2,300,941, if the Certificate of Need has been approved.
Tenet Healthcare Corporation may fund this project utilizing either debt or cash flow from operations, or a combination thereof, as part of its overall capital investment budget. At this time, Tenet has sufficient resources to fully fund the expenditures described in this application along with its other ongoing obligations. In addition to the commitment of the capital expenditure for this project, Tenet Healthcare Corporation hereby commits to provide working capital a necessary for this project,

Sincerely,

Doug Carter
Chief Financial Officer
Southern Region

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Economic Feasibility, Item 4

Revised Pages 28 and 29
Historical Data Chart

Historical Data Chart for SFH-Bartlett Emergency Dept.

Revised Pages 31 and 32
Projected Data Chart

Projected Data Chart for SFH-Bartlett

SUPPLEMENTAL #1

January 30, 2017
11:56 am

HISTORICAL DATA CHART
Saint Francis Hospital-Bartlett

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure: ***patient days***)	30,737	33,223	36,676
B. Revenue from Services to Patients			
1. Inpatient Services	**$ 339,227,427**	**$ 363,665,285**	**$ 428,902,679**
2. Outpatient Services	228,099,959	261,262,618	306,150,501
3. Emergency Services	67,437,140	77,596,583	91,071,396
4. Other Operating Revenue (Specify) Gift Shop, Cafeteria	530,100	1,805,340	1,660,430
Gross Operating Revenue	**$ 635,294,626**	**$ 704,329,826**	**$ 827,785,006**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	**$ 512,637,970**	**$ 569,443,726**	**$ 673,335,213**
2. Provision for Charity Care	315,265	3,686,452	4,552,862
3. Provisions for Bad Debt	14,803,643	15,839,479	17,425,039
Total Deductions	**$ 527,756,878**	**$ 588,969,657**	**$ 695,313,114**
NET OPERATING REVENUE	**$ 107,537,748**	**$ 115,360,169**	**$ 132,471,892**
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$ 29,499,272	$ 30,439,487	$ 33,147,192
b. Non-Patient Care	10,702,694	10,678,713	12,761,215
2. Physician's Salaries and Wages	0	0	0
3. Supplies	18,307,492	19,706,664	24,213,739
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates	501,840	482,536	785,029
5. Management Fees:			
a. Paid to Affiliates	0	0	0
b. Paid to Non-Affiliates	0	0	0
6. Other Operating Expenses	$ 22,442,982	$ 25,103,916	$ 26,654,373
Total Operating Expenses	**$ 81,454,280**	**$ 86,321,316**	**$ 97,561,548**
E. **Earnings Before Interest, Taxes and Depreciation**	**$ 26,083,468**	**$ 29,038,853**	**$ 34,910,344**
F. Non-Operating Expenses			
1. Taxes	$ 2,950,884	$ 4,407,491	$ 5,998,932
2. Depreciation	5,137,782	5,268,350	7,714,668
3. Interest	9,773,850	8,659,210	6,621,781
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	**$ 17,862,516**	**$ 18,335,051**	**$ 20,335,381**
NET INCOME (LOSS)	**$ 8,220,952**	**$ 10,703,802**	**$ 14,574,963**

Chart Continues Onto Next Page

4821-4441-3760.11

SUPPLEMENTAL #1

January 30, 2017

11:56 am

NET INCOME (LOSS)	**$ 8,220,952**	**$ 10,703,802**	**$ 14,574,963**
G. Other Deductions			
1. Annual Principal Debt Repayment	**$**	**$**	**$**
2. Annual Capital Expenditure	6,532,293	3,247,704	315,049
Total Other Deductions	**$ 6,532,293**	**$ 3,247,704**	**$ 315,049**
NET BALANCE	**$ 1,688,659**	**$ 7,456,098**	**$ 14,259,914**
DEPRECIATION	**$ 5,137,782**	**$ 5,268,350**	**$ 7,714,668**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 6,826,441**	**$ 12,724,448**	**$ 21,974,582**

X Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 13,929,782	$ 15,401,987	$ 16,888,188
2. Utilities	1,555,604	1,752,052	1,678,236
3. Repairs and Maintenance	1,977,912	2,148,055	2,333,905
4. Minor Equipment	290,367	290,440	373,290
5. Travel/Dues	324,602	362,326	312,286
6. Advertising	393,912	282,335	269,573
7. Insurance/Property Taxes	3,970,803	4,776,721	4,798,895
Total Other Expenses	**$ 22,442,982**	**$ 25,013,916**	**$ 26,654,373**

SUPPLEMENTAL #1

January 30, 2017
11:56 am

HISTORICAL DATA CHART

Saint Francis Hospital-Bartlett-ED

☐ Total Facility
☐ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure: visits)	30,737	33,223	36,676
B. Revenue from Services to Patients			
1. Inpatient Services	$	$	$
2. Outpatient Services			
3. Emergency Services	$ 67,437,140	$ 77,596,583	$ 91,071,396
4. Other Operating Revenue (Specify) Gift Shop/Cafeteria	-0-	-0-	-0-
Gross Operating Revenue	**$ 67,437,140**	**$ 77,596,583**	**$ 91,071,396**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	**$ 34,392,941**	**$ 39,574,257**	**$ 46,446,412**
2. Provision for Charity Care	6,743,714	7,759,658	9,107,140
3. Provisions for Bad Debt	7,890,145	9,078,800	10,655,353
Total Deductions	**$ 49,026,801**	**$ 56,412,716**	**$ 66,208,905**
NET OPERATING REVENUE	**$ 18,410,339**	**$ 21,183,867**	**$ 24,862,491**
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$ 3,203,172	$ 3,447,577	$ 3,359,176
b. Non-Patient Care	150,000	165,000	175,500
2. Physician's Salaries and Wages			
3. Supplies	584,070	579,937	649,910
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
5. Management Fees:			
b. Paid to Affiliates			
b. Paid to Non-Affiliates			
6. Other Operating Expenses	$ 1,083,619	$ 1,748,763	$ 1,781,708
Total Operating Expenses	**$ 5,020,861**	**$ 5,941,277**	**$ 5,965,394**
E. **Earnings Before Interest, Taxes and Depreciation**	**$ 13,389,478**	**$ 15,242,590**	**$ 18,897,097**
F. Non-Operating Expenses			
1. Taxes	**$ 1,472,843**	**$ 1,676,685**	**$ 2,078,681**
2. Depreciation	156,204	160,891	167,327
3. Interest			
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	**$ 1,629,047**	**$ 1,837,576**	**$ 2,246,007**
NET INCOME (LOSS)	**$ 11,760,432**	**$ 13,405,014**	**$ 16,651,090**

Chart Continues Onto Next Page

SUPPLEMENTAL #1

January 30, 2017

11:56 am

NET INCOME (LOSS)	**$ 11,760,432**	**$ 13,405,014**	**$ 16,651,090**
G. Other Deductions			
1. Annual Principal Debt Repayment	**$**	**$**	**$**
2. Annual Capital Expenditure	$ 1,700	$ 17,025	$ 4,350
Total Other Deductions	**$ 1,700**	**$ 17,025**	**$ 4,350**
NET BALANCE	**$ 11,758,732**	**$ 13,387,989**	**$ 16,646,740**
DEPRECIATION	**$ 156,204**	**$ 160,891**	**$ 167,327**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 11,914,936**	**$ 13,548,880**	**$ 16,814,066**

□ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett - ED

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	**$ 951,382**	**$ 1,607,215**	**$ 1,643,101**
2. Utilities	71,500	71,500	71,500
3. Repairs/Maintenance	35,453	35,662	26,849
4. Minor Equipment	5,227	3,801	10,287
5. Travel/Dues	614	2,462	50
6. Advertising	15,000	22,500	24,200
7. Insurance/Property Taxes	4,443	5,623	5,721
Total Other Expenses	**$ 1,083,619**	**$ 1,748,763**	**$ 1,781,708**

SUPPLEMENTAL #1

January 30, 2017
11:56 am

PROJECTED DATA CHART
Saint Francis Hospital-Bartlett

X Total Facility
□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 1	Year 2
A.	Utilization Data (Specify unit of measure: patient days)	34,680	34,884
B.	Revenue from Services to Patients		
	1. Inpatient Services	$ 515,421,125	$ 546,346,393
	2. Outpatient Services	477,907,020	513,714,374
	3. Emergency Services	15,874,322	19,569,476
	4. Other Operating Revenue (Specify) Gift Shop/Cafeteria	580,260	591,285
	Gross Operating Revenue	**$1,009,782,727**	**$1,080,221,528**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$ 834,103,663	$896,888,458
	2. Provision for Charity Care	7,750,637	8,255,905
	3. Provisions for Bad Debt	20,265,864	20,938,305
	Total Deductions	**$ 862,120,164**	**$ 926,082,668**
NET OPERATING REVENUE		$ 147,662,563	$ 154,138,860
D.	Operating Expenses		
	1. Salaries and Wages	51,766,530	54,215,676
	a. Direct Patient Care	38,048,400	39,848,522
	b. Non-Patient Care	13,718,130	14,367,154
	2. Physician's Salaries and Wages		
	3. Supplies	25,354,732	26,479,190
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	1,965,549	1,972,806
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	28,914,991	29,873,972
	Total Operating Expenses	**$ 108,001,802**	**$ 112,541,644**
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 39,660,761	$ 41,597,216
F.	Non-Operating Expenses		
	1. Taxes	$ 5,949,114	$ 6,239,582
	2. Depreciation	8,126,499	8,434,154
	3. Interest	6,621,781	6,621,781
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	**$ 20,697,394**	$ 21,295,517
NET INCOME (LOSS)		$ 18,963,367	$ 20,301,699

Chart Continues Onto Next Page

SUPPLEMENTAL #1

January 30, 2017

11:56 am

NET INCOME (LOSS)	$ 18,963,367	$ 20301,699
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure	11,000	11,000
Total Other Deductions	**$ 11,000**	**$ 11,000**
NET BALANCE	**$ 18,952,367**	**$ 20,290,699**
DEPRECIATION	**$ 8,126,499**	**$ 8,434,154**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 27,078,866**	**$ 28,724,853**

X☐ Total Facility
☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett

OTHER EXPENSES CATEGORIES	Year 1	Year 2
1. Professional Services Contract	**$ 19,127,788**	**$ 19,723,429**
2. Utilities	1,719,858	1,773,423
3. Repairs/Maintenance	2,467,834	2,554,683
4. Minor Equipment	298,739	308,050
5. Travel/Dues	499,840	515,438
6. Advertising	457,116	471,357
7. Insurance/Property Taxes	4,343,816	4,537,592
Total Other Expenses	**$ 28,914,991**	**$ 29,873,972**

SUPPLEMENTAL #1

January 30, 2017
11:56 am

PROJECTED DATA CHART
Saint Francis Hospital-Bartlett FSED

Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 1	Year 2
A.	Utilization Data (visits)	5,591	6,656
B.	Revenue from Services to Patients		
	1. Inpatient Services	$0	$0
	2. Outpatient Services	0	0
	3. Emergency Services	$15,874,322	$19,569,476
	4. Other Operating Revenue (Specify)		
	Gross Operating Revenue	**$15,874,322**	**$19,569,476**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$9,984,000	$12,020,000
	2. Provision for Charity Care	914,000	1,090,000
	3. Provisions for Bad Debt	405,000	503,000
	Total Deductions	**$11,303,000**	**$13,613,000**
NET OPERATING REVENUE		$4,571,322	$5,956,476
D.	Operating Expenses		
	1. Salaries and Wages	2,743,377	2,839,395
	a. Direct Patient Care	2,437,201	2,522,503
	b. Non-Patient Care	306,176	316,892
	2. Physician's Salaries and Wages	0	0
	3. Supplies	57,807	75,060
	4. Rent		
	a. Paid to Affiliates	0	0
	b. Paid to Non-Affiliates	1,136,723	1,141,790
	5. Management Fees:		
	a. Paid to Affiliates	0	0
	b. Paid to Non-Affiliates	0	0
	6. Other Operating Expenses	892,011	919,065
	Total Operating Expenses	**$ 4,829,918**	**$ 4,975,850**
E.	**Earnings Before Interest, Taxes and Depreciation**	($ 258,596)	$ 981,298
F.	Non-Operating Expenses		
	1. Taxes	$ 0	$ 147,195
	2. Depreciation	245,000	245,000
	3. Interest	0	0
	4. Other Non-Operating Expenses	0	0
	Total Non-Operating Expenses	**$ 245,000**	**$ 392,195**
NET INCOME (LOSS)		($ 503,593)	$ 589,103

Chart Continues Onto Next Page

SUPPLEMENTAL #1

January 30, 2017
11:56 am

NET INCOME (LOSS)	**($ 503,596)**	**$ 589,103**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ 0	$ 0
2. Annual Capital Expenditure	$ 11,000	$ 11,000
Total Other Deductions	**$ 11,000**	**$ 11,000**
NET BALANCE	**($ 514,596)**	**$ 578,103**
DEPRECIATION	**$ 245,000**	**$ 245,000**
FREE CASH FLOW (Net Balance + Depreciation)	**($ 269,596)**	**$ 823,103**

☐ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett FSED

OTHER EXPENSES CATEGORIES	Year 1	Year 2
1. Professional Services Contract	**$ 639,251**	**$ 659,262**
2. Utilities	173,760	178,973
3. Repairs/Maintenance	5,000	5,150
4. Minor Equipment	15,000	15,450
5. Travel/Dues	9,000	9,270
6. Advertising	50,000	51,500
7. Insurance/Property Taxes		
Total Other Expenses	**$ 892,011**	**$ 919,605**

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Economic Feasibility, Item 5.A and 6.B

Revised Page 33

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year-SFH-2014	Current Year-SFH-ED 2015	Year One-FSED-2019	Year Two-FSED-2020	% Change (Year 1 to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	2,336	2,483	2,839	2,940	+3.6%
Deduction from Revenue *(Total Deductions/Utilization Data)*	1,698	1,805	2,021	2,045	+1.2%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	638	678	818	895	+9.5%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: See table above for gross charges both for SFH-Bartlett ED and the proposed FSED. Because the overall acuity level of the patients is expected to be lower than the acuity level of the patients treated at the SFH-Bartlett ED, the charges are less for the FSED.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Please see information below:

CPT Code	Procedure Level	Current Rate
99281	Level 1	$56.53
99282	Level 2	$102.68
99283	Level 3	$185.38
99284	Level 4	$306.20
99285	Level 5	$450.21

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. **NOTE: Publicly held entities only need to reference their SEC filings.**

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Economic Feasibility, Item 5.A and 6.B

Revised Page 34

Response: The applicant expects to reach the break-even point during the second year of operation, and generate positive cash flow in the second year of operation as well. Included as Attachment C, Economic Feasibility 6-A is the 10-K SEC filing for Tenet, the ultimate parent company of the applicant.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	.7273	.7195	.7601	-.05666	.1647

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: The applicant believes the capitalization ratio to be 95% based on the Tenet 10Q for the quarterly period ended September 30, 2016, which is the most recent data available.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: Please see the chart below for the applicant's projected payor mix

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	3,968,581	25.0
TennCare/Medicaid	3,730,466	23.5
Commercial/Other Managed Care	5,476,641	34.5
Self-Pay	1,206,448	7.6
Charity Care	873,088	5.5
Other (Specify) Private/Exchange	619,099	3.9
Total	15,874,322	100

SUPPLEMENTAL #1

January 30, 2017
11:56 am

Attachment Section B, Contribution to the Orderly Development, Item 1

List of Managed Care Organizations

SUPPLEMENTAL #1

January 30, 2017
11:56 am

MANAGED CARE ORGANIZATIONS

AARP Medicare PPO
Aetna HMO, PPO, POS)
Aetna Medicare Advantage HMO
Aetna NAP
Aetna Signature
Amerigroup Tenncare
America's Choice Network
United Community Hlth Plan Americhoice
BCTN Network P, S, TennCare Select
Blue Care TennCare
Blue Care Plus Dual Eligibility
Blue Cross Advantage Medicare PPO
Blue Cross Network S Exchange
CIGNA Gatekeeper/Flexcare RPO, HMO, PPO
CIGNA
CoastalComp Health Networks (Workers Comp)
Community Health Alliance Exchange
Corvel (CorCare)
Coventry National
First Health
HealthLink PPO, HMO
Health Management Network
HealthSmart Network Workers Comp
HealthSmart/Health Payors ORG Network PPO (HPO Wrap Business) (Interplan Hlth Grp)
HealthSmart/ Interplan Health Group PPO (IHG Direct Business)
HealthSpring Medicare HMO
MultiPlan
National Provider Network
National Preferred Provider Network
Prime Health Services f.k.a. CompPlus
Private Healthcare Systems PPO
Provider Select
Three Rivers Health Plan, Workers Comp
Three Rivers Workers Com
UHC Community Plan Medicare
United Healthcare
USA Managed Care WCMC
USA Managed Care EPO
Windsor Medicare HMO--

SUPPLEMENTAL #1
January 30, 2017
11:56 am

waller

Waller Lansden Dortch & Davis
511 Union Street, Suite 2700
Nashville, TN 37219-8966
615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

February 17, 2016

VIA HAND DELIVERY

Melanie M. Hill
James B. Christoffersen, Esq.
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Baptist Memorial Hospital - Lakeland CN1508-037

Dear Melanie and Jim:

At the hearing in November for the Baptist FSED, there were some questions regarding provider-based status and reimbursement. We wanted to provide clarification to the agency members as to how the provider-based status and reimbursement works. The Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") sets forth specific requirements in 42 C.F.R. § 413.65 that must be met in order for an entity to be treated as provider-based for purposes of reimbursement under the Medicare and Medicaid program. Included below are those which are most relevant to this CON Application. The comments in italics address specifics either from the application or from the hearing in November for its related application. In this discussion, the FSED is the provider-based facility and Baptist is the main provider.

1. Ownership and Control (42 C.F.R. § 413.65(e)(1)).

   * The provider-based facility must be 100% owned by the main provider; Regional One can have no ownership in the provider-based facility.

   * The provider-based facility must have the same governing body as the main provider.

   * The provider-based facility must be under the administrative and financial control of the main provider.

   * The provider-based facility is operated under the same organizational documents as the main provider. For example, the provider-based facility must be subject to common bylaws and operating decision of the governing body of the main provider.

waller

* No joint venture is permissible in an off-campus location such as the one proposed.

  * *According to the application, a new LLC is being formed that will be owned 60% by Baptist and 40% by Regional One to house and/or lease the real estate and equipment to be used at the provider-based facility and provide a structure to capitalize the same. As a real estate and/or leasing JV, the expenses and profits from this venture can be shared with Regional One in proportion to its ownership interest in the JV - which is not the same as sharing the profits and expenses of the provider-based facility. The lease to the provider-based facility must be fair market value.*

2. Licensure (42 C.F.R. § 413.65(d)(1)).

   * The provider-based facility and the main provider are under the same license.

3. Clinical Services Integration (42 C.F.R. § 413.65(d)(2) & (i)).

   * Professional staff at the provider-based facility have privileges at the main provider.

   * The main provider maintains the same monitoring and oversight of the provider-based facility as it does for any other department.

   * Inpatient and outpatient services of the provider-based facility and the main provider are integrated.

4. Financial Integration (42 C.F.R. § 413.65(d)(3)).

   * The financial operations of the provider-based facility are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the provider-based facility. The costs are reported in a cost center of the main provider, and the financial status of the provider-based facility is incorporated and readily identified in the main provider's trial balance.

   * Medicare will pay the main provider for the services provided at the provider-based facility.

     * *Under the provider-based rules, there is no mechanism to share profits and losses of the provider-based facility with Regional One. This proposal is not a joint venture which would allow such sharing based on the respective ownership interests of* the provider-based facility*; the provider-based facility in this situation is 100% owned by Baptist.*

waller

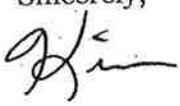
5. Public Awareness (42 C.F.R. §413.65(d)(4)).

* The provider-based facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility they are aware that they are entering the main provider and are billed accordingly.

* *Any opportunities for co-branding of the provider-based facility with Regional One would be limited, if they exist at all.*

While there are certainly a number of other specific requirements that must be met, these are the most relevant based on the application and the discussion at the last hearing. Please do not hesitate to request additional information or clarification on this issue.

Sincerely,



Kim Harvey Looney

KHL:lag

SUPPLEMENTAL #1

January 30, 2017
11:56 am

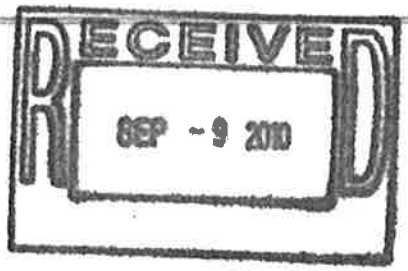
Attachment Section B, Contribution to the Orderly Development, Item 4.A and 4.B

Department of Health Letter

SUPPLEMENTAL #1

January 30, 2017
11:56 am

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305



September 7, 2010

Mr. Kem Mullins, CEO/Administrator
St. Francis Hospital Bartlett
2986 Kate Bond Road
Bartlett, TN 38133

Dear Mr. Mullins:

On **September 3, 2010**, a surveyor from our office completed a review of your plan of correction for deficiencies cited as a result of **licensure survey** of **August 17, 2010**. Based on the review, we are accepting your plan of correction and are assuming your facility is in compliance with all participation requirements as of **September 3, 2010**.

If this office may be of any assistance to you, please do not hesitate to 731-984-9711.

Sincerely,

Celia Skelley

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

TW

CS/TW

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2010
NAME OF PROVIDER OR SUPPLIER SAINT FRANCIS BARTLETT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2986 KATE BOND RD BARTLETT, TN 38133		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 608	1200-8-1-.06 (1)(c)2. Basic Hospital Functions (1) Performance Improvement. (c) The hospital must have an ongoing plan, consistent with available community and hospital resources, to provide or make available social work, psychological, and educational services to meet the medically-related needs of its patients which assures that: 2. Patients, along with their necessary medical information, are transferred or referred to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to refer a potential case of abuse for 1 of 12 (Patient #18) sampled emergency room patients. The findings included: Medical record review for Patient #14 documented the patient [5 years old] presented at the Emergency Department (ED) on 6/13/10 at 10:14 PM with a triage time of 10:25 PM. The triage notes documented, " Mother states: right knee, right injury...dancing and fell onset 30 min [minutes] ago..." Further review documented the patient left without being seen at 11:16 PM. There was no documentation the hospital made a referral to the Department of Human Services (DHS) or had done any type of follow-up.	H 608	We reviewed our current Nursing/Patient Care Services policy "Emergency Center Discharge Calls". While the policy required discharge calls to "parents of pediatric patients", we felt the need to make additions to the policy specific to "parents of all pediatric patients that have left without being seen or against medical advice". A copy of the revised policy is provided as Attachment A. Emergency Care Center staff, Administrative Supervisor staff, and Social Worker staff will be educated on the revision, processes, and accountabilities prior to September 17, 2010. Compliance with the policy will be monitored through a cross-check of patients seen, left without being seen, or left against medical advice and the discharge call log. 9/2/10	

Division of Health Care Facilities

KEN M. MULLINS, FACHE

TITLE Chief Executive Officer (X6) DATE 9-2-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2010
NAME OF PROVIDER OR SUPPLIER: SAINT FRANCIS BARTLETT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 2986 KATE BOND RD BARTLETT, TN 38133		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 608	Continued From page 1 In an interview in the conference room on 8/17/10 at 10:18 AM, the ED [Emergency Department] Director verified no follow-up had been done and stated the facility had no policy in place for children who left the ED without being seen.	H 608		
H 681	1200-8-1-.06 (4)(g) Basic Hospital Functions (4) Nursing Services. (g) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient ' s needs and the specialized qualifications and competence of the nursing staff available. All nursing personnel assigned to special care units shall have specialized training and a program in-service and continuing education commensurate with the duties and responsibilities of the individual. All training shall be documented for each individual so employed, along with documentation of annual competency skills. This Rule is not met as evidenced by: Based on facility policy, observation and interview, nursing services failed to ensure all medications were current and maintained in a secure manner. The findings included: 1. Review of the facility's policy "Medication Storage After Retrieval" documented, "...2) Locked medication carts. If the nursing floor utilizes medication carts with patient bed-specific bins, retrieved items may be kept in the patient's bin for a maximum of four (4) hours excluding	H 681	We reviewed all policies related to medication storage, distribution, and administration related to use and integrity of medication carts as referenced in the standard. Admittedly, policies were not as clear and easily interpreted as we would have hoped. In support of two existing Pharmacy policies, Nurse Services drafted/issued a new policy "Medication Cart: Use and Integrity" which provides specifics of accountability for maintaining medication carts locked when not in use. The policy is provided as Attachment B. Nursing staff on patient care units that utilize medication carts will be educated on the policy, processes, and accountabilities prior to September 17, 2010. Compliance with the policy will be monitored through daily nursing director rounds, administrative supervisor rounding, spontaneous unit visits by Pharmacy staff or the nursing leadership group, as well as participants in Environment of Care rounding. Non-compliance will be addressed individually by the unit nursing director in accordance with our standard progressive disciplinary policy. We reviewed all policies related to medication storage, out-of-date returns, and floor stock inspections for pertinence in reference to outdated medications as referenced by the standard. All policies were found to be clear in their intent and interpretation. (continued →)	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531161	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/17/2010
NAME OF PROVIDER OR SUPPLIER: SAINT FRANCIS BARTLETT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 2986 KATE BOND RD BARTLETT, TN 38133		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 681	Continued From page 2 scheduled II/III/IV." 2. During the initial tour of the facility on 8/16/10 at 9:59 AM outside room 311, a medication cart was observed to be unlocked and unattended by licensed personnel. The Infection Preventionist verified that the medication cart was unlocked and unattended. 3. Observations in the ED medication room 8/16/107 at 10:40 AM, the medication storage area was observed to contain 8 prefilled syringes of Epinephrine with the expiration date of 8/13/10. During an interview in the medication room on 8/16/10 at 10:40 AM, the RN [Registered Nurse] charge nurse verified the expired medications should not still be in the medication storage area.	H 681	During our investigation of the prefilled Epinephrine syringes cited in the summary of deficiencies, our Director of Pharmacy relayed to us that Epinephrine supplied in syringe form is available in limited supply. This medication is vital to emergency care and is shipped from a supplier other then the manufacturer which shortens the expiration time to two-months (as it is repackaged). Our resources have indicated that with the short supply and the importance of the medication, a large number of facilities are considering use of the medication for a period exceeding the expiration date. We have not chosen to do this and all expired syringes were removed on the day of discovery (the day/date of the survey). Omnicell automated dispensing cabinets are checked for outdated medications on a monthly basis. These syringes were not removed with the prior check. They had been expired for a period of three (3) days. It was recommended that our processes continue as outlined in our policies. The Director of Pharmacy has instructed his staff of the need to pull these syringes on the date of expiration (as of the day/date of discovery in the survey).	

SUPPLEMENTAL #1
January 30, 2017
11:56 am

Attachment Section B, Contribution to the Orderly Development, Project Completion Forecast Chart

Revised Page 44

SUPPLEMENTAL #1

January 30, 2017
11:56 am

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		4/2017
2. Architectural and engineering contract signed		4/2017
3. Construction documents approved by the Tennessee Department of Health		8/2017
4. Construction contract signed		9/2017
5. Building permit secured		10/2017
6. Site preparation completed		12/2017
7. Building construction commenced		12/2017
8. Construction 40% complete		4/2018
9. Construction 80% complete		8/2018
10. Construction 100% complete (approved for occupancy		10/2018
11. *Issuance of License		N/A
12. *Issuance of Service		1/2019
13. Final Architectural Certification of Payment		11/2018
14. Final Project Report Form submitted (Form HR0055)		2/2019

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

SUPPLEMENTAL #1
January 30, 2017
11:58 am

JAN 30 '17 PM 11:56

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SAINT FRANCIS HOSPITAL-BARTLETT CN1701-004

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30th day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass

NOTARY PUBLIC

My commission expires: January 8, 2019.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JANUARY 8, 2019

HF-0043

Revised 7/02

Supplemental #2
-Original-

St Francis Hospital Bartlett

CN1701-004

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

615.244.6380 main
615.244.6804 fax
wallerlaw.com

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

January 31, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Saint Francis Hospital-Bartlett CN1701-004
Second Supplemental Request

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 31, 2017, wherein additional information or clarification was requested regarding the above-referenced CON application.

---

1. **Section A, Project Details, Item 4.A Legal Interest**

   It is noted the Option to Lease agreement is between the applicant and the real estate developer Capital Growth Medvest, LLC. Capital Growth Medvest, LLC has an agreement with Hynman Holdings, LLC and T. David Goodwin, Jr. for the sale of the proposed FSED site. However, please provide documentation that Hynman Holdings, LLC and/or T. David Goodwin, Jr. has legal possession and control of the proposed site. Please provide a copy of a current deed to confirm ownership.

   Response: There are 2 parcels of land which comprise the site for the proposed FSED, and 2 Purchase and Sale Agreement. One of them is owned by P.F. Holdings, Inc. The other is controlled by TDG Investment, LLC, Trails, LLC, and Hyneman Holdings, LLC. In addition to the deeds for both parcels, there is also a First Amendment to Purchase and Sale Agreement for the property owned by 3 parties, which has been executed by all 3. Together they own 100% of the second parcel. Please see copy of deeds and the First Amendment to the Purchase and Sale Agreement included in Attachment Section A, Project Details, Item 4.A Legal Interest.

2. **Section B, Need, Item 3. (Proposed Service Area)**

   The historical utilization table on page replacement 17 is noted. However, the total utilization for Fayette County of 3.043 appears incorrect. Please correct and submit a replacement page 17.

waller

Response: The period in 3.043 is the result of a transcription error and should have been a comma. Please note that the population of Fayette County should be 3,043 rather than 3.043. A revised replacement page 17 is included as Attachment Section B, Need, Item 3. (Proposed Service Area).

3. **Section B, Need, Item 5.**

The following table for the historical and projected ED volumes of SFH-Bartlett from 2014-2017 by level of care consistent with CPT codes 99281 (lowest acuity), 99282, 99283, 99284 and 99285 (highest acuity patient) is noted. However, the total in the first column for the 2014 main ED is incorrect. Please revise and submit a new chart.

Response: Please see chart below with corrected total for 2014.

SFH-Bartlett Historical and Projected Utilization by Level of Care

Level of Care	Main ED	Main ED	Main ED	Main ED	Satellite ED	Combined Year 1
	2014	2015	2016	Year 1	Year 1	
Level I	1,604	894	743	786	1,230	2,016
Level II	2,634	3,322	3,300	3,493	1,677	5,170
Level III	12,070	13,605	13,420	14,204	1,789	15,993
Level IV	15,576	14,903	15,460	16,363	839	17,202
Level V	6,491	9,496	10,721	11,347	56	11,403
Total	38,375	42,220	43,644	46,193	5,591	51,784

The following chart for projected ED utilization by zip code in in Year 1 of the proposed Satellite ED project for zip codes with patient origin over 0.15% is noted. However, the population total of 122,253 provided by the applicant is incorrect. Please revise and submit a new chart.

Response: Please see chart below with the corrected zip code population.

Projected Utilization by Zip Codes in Applicant's Proposed Service Area, Year 1

Patient Zip Code	Name	Population	Main ED Visits Year 1	Proposed Satellite ED Visits Year 1	Total ED Visits	% by Zip Code	Cumulative %
38002	Arlington	41,561	4,562	1,939	6,501	37%	37%
38028	Eads	6,498	486	308	794	5%	42%
38053	Millington	29,390	2,037	1,312	3,349	19%	61%
38060	Oakland	10,512	2,553	817	3,369	19%	80%
38068	Somerville	10,865	1,616	596	2,212	13%	93%
38012	Brownsville	14,763	80	163	244	1%	94%
38069	Stanton	2,615	88	151	239	1%	95%
38049	Mason	4,940	544	305	849	5%	100%
Total		121,144	11,966	5,591	17,557	N/A	N/A

4. **Section B. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)**

The Historical Data Chart for the total facility is noted. The 2014 total operating expenses in the amount of $86,321,316 is incorrect. Also, 2014 D.6 "Other Operating Expenses" in the amount of $25,103,916 on the Historical Data Chart is listed on page R-29 in the itemized breakdown of "Other Expenses" as $25,013,916. Please correct the following and submit a revised Historical Data Chart.

Response: The $86,321,316 figure is correct as is the $25,013,916 figure located in the other expenses table. There was a transcription error in the reported $25,103,916 "other expenses" category on the Historical Data Chart for 2014 that has since been corrected to $25,013,916, resulting in the correct figures overall. Please see attached revised page 28 included as Attachment Section B, Economic Feasibility, Item 4.

The Historical Data Chart for the applicant's existing Emergency Department is noted. However, the 2015 total operating expenses total of $5,965,394 is incorrect. Please revise and submit a revised Historical Data Chart.

Response: The Supplies number had a typographical error and has been corrected. The total operating expenses is correct at $5,965,394. The revised Historical Data Chart for the Emergency Department is included as Attachment Section B, Economic Feasibility, Item 4.

The Projected Data Chart for SFH-Bartlett is noted. However, please remove the duplicative Year 1 and Year 2 Salaries and Wages Expenses of $51,766,530 and $54,215,676. Also, the Other Operating Expense total of $29,873,972 appears to be calculated incorrectly for Year Two on page two of the Projected Data Chart "Other Expenses" Itemized Breakout. Please correct and submit a replacement Projected Data Chart.

Response: Please see the attached revised Projected Data Chart for SFH-Bartlett included as Attachment Section B, Economic Feasibility, Item 4. The duplicative Year 1 and Year 2 Salaries and Wages Expenses have been removed. The figure for Repairs/Maintenance under Other Operating Expenses has been corrected to $2,544,683 so that the total Other Operating Expense figure of $29,873,972 is now correct.

The Projected Data Chart for SFH-Bartlett FSED is noted. However, please remove the duplicative Year 1 and Year 2 Salaries and Wages expenses of $2,743,377 and $2,839,395. Also, the Year 2 Total operating Expenses of $4,975,850 appears to be incorrect. Also, the Year 2 total operating expenses of $919,065 is different from the Year 2 total operating expenses total of $919,605 as listed on page R-32. Please revise and submit a new Projected Data Chart.

Response: Please see the attached revised Projected Data Chart for SFH-Bartlett FSED included as Attachment Section B, Economic Feasibility, Item 4. The other operating expenses total of

SUPPLEMENTAL #2
January 31, 2017
3:18 pm
JAN 31 '17 PM 3:19

waller

$919,065 originally reported in the chart was the result of a transcription error. The corrected figure of $919,605 is now properly reported. This correction leads to the total operating expenses figure of $4,975,850 also being the correct figure for Year 2.

5. **Section B. Economic Feasibility Item 6.B**

The Net Operating Margin Ratio table for the existing ED and proposed FSED is noted. However, the please provide a Net Operating Margin Ratio table for SFH-Bartlett Hospital using the Historical and Projected Data Charts.

Response: Please see attached revised page 34 which has the net operating margin for the entire hospital included as Attachment Section B, Economic Feasibility-Item 6.B.

Please contact me if you have any questions or need additional information or clarification.

Sincerely,

Kim Harvey Looney

KHL:lag
Attachments

JAN 31 '17 PM 3:19

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

Attachment Section A, Project Details, Item A

Deed for Parcel Owned by PF Holdings

Amendment to Purchase and Sale Agreement

Deed for Parcel Owned by TDG Investment, LLC, Trails, LLC and Hyneman Holdings, LLC

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

08134166

10/10/2008 - 01:51 PM

2 PGS : R - QUIT CLAIM

VIRGINIA 603526-8134166

VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	10.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	12.00

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

This instrument was prepared by:
Rodney S. Klein, Esq.
KLEIN & ASSOCIATES, Attorneys at Law
110 Corporate Drive, Suite 150, Johnson City, TN 37604

QUITCLAIM DEED

THIS QUITCLAIM DEED, made and entered into this, the 1 day of October, 2008, by and between PAUL FISHER OIL COMPANY, INC., herein called Party of the First Part, and P.F. HOLDINGS, INC., herein called Party of the Second Part.

WITNESSETH:

THAT FOR AND IN CONSIDERATION of the sum of Ten Dollars ($10.00) cash in hand paid, the receipt of which is hereby acknowledged, the Party of the First Part has bargained and sold and by these presents does grant, transfer, quitclaim and convey unto the Party of the Second Part, its successors and assigns, the following described property more particularly bounded and described as follows, to-wit:

Shelby County – Tax ID: A0152 00213

Situate in Shelby County, State of Tennessee:

Lot I, Resubdivision of Parcel III, Bond Motor Company Property, recorded at Plat Book 161, Page 27, in the Shelby County, TN Register's Office, and being more particularly described as follows:

Beginning at a found stake in the proposed southerly R.O.W. of Interstate Highway I-40 (centerline station 337+75.48, 376.36 Feet right, thence north 41 degrees 37 minutes 16 seconds east along said proposed southerly line a distance of 137.08 Feet to a found stake (Centerline station 339+10, 350.00 Feet right); thence north 32 degrees 18 minutes 54 seconds east along said proposed southerly line a distance of 133.69 Feet to a set iron pin; thence south 37 degrees 17 minutes 00 seconds east a distance of 289.01 Feet to a set iron pin, thence south 52 degrees 43 minutes 00 seconds west a distance of 267.84 Feet to a set iron pin in the westerly line of New Airline Road (122.00 Feet from centerline), thence north 37 degrees 17 minutes 00 seconds west a distance of 152.42 Feet to a point, thence north 52 degrees 43 minutes 00 seconds east a distance of 7.97 Feet to a found stake in the proposed R.O.W. of said New Airline Road (centerline station 25+60, 130.55 Feet right); thence north 37 degrees 14 minutes 43 seconds west a distance of 63.61 feet to the point of beginning.

BEING the same property conveyed to the Party of the First Part by Carruthers & Mays, LLC, by deed dated May 31st, 2000 of record in the Register's Office for Shelby County, Tennessee Instrument Number KG 0195.

This conveyance is made subject to any and all valid restrictive covenants and easements as may appear of record, if any.

IN WITNESS WHEREOF, an authorized representative of the Party of the First Part hereunto signs this Deed on the day and year first above written.

PAUL FISHER OIL COMPANY, INC.,

Paul Fisher

PAUL FISHER, PRESIDENT

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

STATE OF TENNESSEE)
COUNTY OF Madison)

On this 1 day of October, 2008, before me appeared **PAUL FISHER**, the within named, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who acknowledged that he executed the within instrument as President of PAUL FISHER OIL COMPANY, INC. and with authority to act for the same.

WITNESS my hand and seal of office in the State and County aforesaid this 1 day of October, 2008.

NOTARY PUBLIC

ALICIA P. KITE STATE OF TENNESSEE NOTARY PUBLIC SULLIVAN COUNTY

My commission expires 6/2/10.

STATE OF TENNESSEE)
COUNTY OF Madison)

I, or we, hereby swear or affirm that the actual consideration for this transfer, or value of the property or interest in property transferred, whichever is greater, is $-0-, which amount is equal to or greater than the amount which the property or interest in property transferred would command at a fair and voluntary sale.

Paul Fisher
AFFIANT

Sworn to and subscribed before me, this 1 day of October, 2008.

NOTARY PUBLIC

ALICIA P. KITE STATE OF TENNESSEE NOTARY PUBLIC SULLIVAN COUNTY

My commission expires: 6/2/10.

NAME & ADDRESS OF PROPERTY OWNER:

P. F. HOLDINGS, INC.
P.O. Box 268
Selmer, TN 38375

NAME & ADDRESS OF PERSON OR ENTITY RESPONSIBLE FOR PAYMENT OF REAL PROPERTY TAXES:

P. F. HOLDINGS, INC.
P.O. Box 268
Selmer, TN 38375

THE LEGAL DESCRIPTION OF THE REAL ESTATE HAS BEEN FURNISHED TO THE DRAFTSMAN BY THE GRANTOR(S) OR A THIRD PARTY OR HAS BEEN OBTAINED FROM THE PUBLIC RECORDS. THE DRAFTSMAN ASSUMES NO LIABILITY AS TO THE ACCURACY OR CONTENT THEREOF REGARDLESS OF WHETHER THE SAME IS DUE TO THE INFORMATION PROVIDED OR DRAFTSMAN'S ERROR. NO OPINION AS TO THE STATE OF TITLE HAS BEEN FURNISHED AND THE GRANTEE(S) SHOULD SEEK AN INDEPENDENT TITLE EXAMINATION IF DESIRED. THE DRAFTSMAN ASSUMES NO LIABILITY AS TO THE STATE OF TITLE OF THIS REAL ESTATE OR THE ACCURACY OF THIS DEED. FAILURE TO PROMPTLY RECORD THIS DEED IN THE APPROPRIATE REGISTER OF DEEDS' OFFICE COULD JEOPARDIZE THE GRANTEE(S) RIGHTS IN AND TO THIS REAL ESTATE. BY SIGNING THIS DEED THE GRANTOR UNDERSTANDS AND AGREES TO THIS LIMITATION OF LIABILITY AND BY ACCEPTANCE OF THIS DEED THE GRANTEE AGREES TO THE SAME.

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

FIRST AMENDMENT
TO PURCHASE AND SALE AGREEMENT

This **FIRST AMENDMENT TO PURCHASE AND SALE AGREEMENT** (the "First Amendment") is entered into this 31st day of January, 2017, by and between **CAPITAL GROWTH MEDVEST, LLC**, an Alabama limited liability company, or its affiliate or assign **("Buyer")** and **TDG INVESTMENT, LLC**, a Wyoming Close Limited Liability Company, **TRAILS, LLC**, a Wyoming Close Limited Liability Company, and **HYNEMAN HOLDINGS, LLC**, a Tennessee limited liability company (collectively, "Seller").

W I T N E S S E T H:

WHEREAS, T. David Goodwin, Sr., T. David Goodwin, Jr. and Hyneman Holdings, LLC entered into that certain Purchase and Sale Agreement dated January 5, 2017 (the "Contract") for the purchase and sale of certain property containing approximately 2 acres located along New Airline Road in Memphis, Tennessee (the "Premises"), as more particularly described therein; and

WHEREAS, the Premises is owned in fee simple by TDG Investments, LLC, a Wyoming Close Limited Liability Company, as to an undivided 40% interest, Trails, LLC, a Wyoming Close Limited Liability Company, as to an undivided 40% interest, and Hyneman Holdings, LLC, a Tennessee limited liability company, as to an undivided 20% interest, and the parties now wish to amend the Contract to reference the correct names of the Seller of the Premises.

NOW, THEREFORE, for $10.00 consideration and the mutual promises and covenants of the parties hereunder, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. The Seller as defined in the first paragraph of the Contract is hereby amended to be TDG Investments, LLC, a Wyoming Close Limited Liability Company, as to an undivided 40% interest, Trails, LLC, a Wyoming Close Limited Liability Company, as to an undivided 40% interest, and Hyneman Holdings, LLC, a Tennessee limited liability company, as to an undivided 20% interest.

2. The parties hereby acknowledge and agree that the Contract is in full force and effect and hereby ratify all terms and conditions contained therein, subject only to this First Amendment.

3. This First Amendment may be signed in two or more counterparts, each of which shall be considered an original hereof. Facsimile or .pdf signatures will be deemed the equivalent of original "wet-ink" signatures for all evidentiary purposes, and the parties agree to accept facsimile signatures as such.

4. Except as specifically set forth in this First Amendment, the Contract shall remain unmodified and in full force and effect.

IN WITNESS WHEREOF, the parties have executed this First Amendment on the date and year first above written.

BUYER:

CAPITAL GROWTH MEDVEST, LLC, an Alabama limited liability company

By Chad J. Post
Name: Chad J. Post
Title: Authorized Agent

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

SELLER:

TDG INVESTMENT, LLC, a Wyoming Close Limited Liability Company

By_____
Name: T. DAVID GOODWIN
Title: MANAGER

TRAILS, LLC, a Wyoming Close Limited Liability Company

By_____
Name: T. DAVID GOODWIN JR
Title: MANAGER

HYNEMAN HOLDINGS, LLC, a Tennessee limited liability company

By_____
Name: KEVIN HYNEMAN
Title:_____

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

09058721

05/19/2009 - 10:58 AM

3 PGS	
LAKECIA 653180-9058721	
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	17.00

TOM LEATHERWOOD
REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Prepared By and Return To:
WISEMAN BRAY PLLC
1665 Bonnie Lane, Suite 106
Memphis, Tennessee 38016
(901) 372-5003

Tax Parcels A0152 00266
A0152 00267
A0152 00230

CORRECTED QUIT CLAIM DEED

Property Address & New Owner :	*	Mail Tax Statement to:
TRAILS, LLC	*	TRAILS, LLC
6112 Macon Road	*	6112 Macon Road
Memphis, TN 38134	*	Memphis, TN 38134

The GRANTOR, **T. DAVID GOODWIN, JR.**, for and in consideration of Ten Dollars ($10.00), cash in hand paid, together with other good, valuable, and satisfactory consideration, the receipt of all of which is hereby acknowledged, does hereby convey and quit claim all of my right, title and interest in the below-described property to:

TRAILS, LLC,
A Wyoming Close Limited Liability Company

Said real estate is located in Shelby County, Tennessee, and is more particularly described as follows, to-wit:

TRACT ONE

Proposed Area "C", (S-C), being part of 106.5695 Ac. Tract of property as recorded in Warranty Deed JB -0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old ½" iron pipe (found) in the northeast right-of-way of New Airline Road at station 65+57.46, said point being the southeast corner of said Lot 2; Thence northwestwardly along the northeast right-of-way of New Airline Road N. 52d 32' 36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet an angle of 91d 22' 18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d 49' 41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d 07' 52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d 02' 26" E, 593.57 feet to a point; Thence S 86d 24' 00" W, 537.25 feet to an ½" iron pipe (found); Thence N 52d 35' 41" W, along the northeast right-of-way of New Airline Road 78.07 feet to the point of beginning containing 184,875.9 sq. ft or 4.2441 acres.

Being the same property conveyed to T. DAVID GOODWIN, JR by Quit Claim

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

deed of record as Instrument Number KU 2551 in the Register's Office of Shelby County, Tennessee.

TRACT TWO

Lot No. 1 and 2 of, Phase 6, Trails of Arlington, P.D. Beginning at a southwest corner of Lot # 1 of Trails of Arlington P.D., Phase 5, as record in P. B. 224, Page 52, in the Shelby County Register's Office; Thence southwestwardly along the north R.O.W. line of Arlington Trail (68'. R.O.W.), S-64d-56'-16"-W, a distance of 156.89' to a point of curvature; Thence along the curve to the left having a radius of 1171' and an arc distance of 432.30' to the point of tangency; Thence continuing southwestwardly along the said R.O.W. on a relative bearing of S43d-47'-09"-W, a distance of 228.47' to the point of curvature; Thence along the curve to the right having a radius of 35' and an arc distance of 56.57' to the point of combined curve; Thence along the curve to the right having the radius of 1807.86' and an arc distance of 355.46' being also along the east R.O.W. line of New Airline Road (150' R.O.W.) to the point of curvature; Thence continuing northwestwardly along the said R.O.W. on a relative bearing of N-32d-19'-56"-W, a distance of 45.45' to a point; Thence leaving the said R.O.W. along the south line of Lot #1 Re-subdivision of Parcel III, Bond Motor Company (P.B. 161, Pg. 27) on a relative bearing of N-57d-40"-04"-E, a distance of 287.84' to a point; Thence N-32d-19'-56"-W, a distance of 289.59' to the south R.O.W. line of U.S. Interstate I-40; thence northeastwardly along the south line of said R.O.W., on a relative bearing of N-37d-21'08"-E, a distance of 287.61' to a point; Thence continuing along the said R.O.W. on a relative bearing of N-50d-46'-37"-E, a distance of 233.49' to a point; Thence leaving the said R.O.W. along the west line of Lot #1 of Trails of Arlington P.D., Phase 1 (P.B. 203, Page 14) on a relative bearing of S-00d-45'28"–W, a distance of 317-84' to a point; Thence along the south line of said Lot #1 on a relative bearing of N-77d-47'-09"-E, a distance of 340.00' to a point; Thence southeastwardly along the west line of Lot#1 of Trails of Arlington P.D., Phase 5 (P.B. 224, Pg. 52) on a relative bearing of S-25d-03'-44"-E, a distance of 402.47' to the point of beginning, containing 492,905.49 sq. feet or 11.3156 acres.

Being part of 106.5895 ac. Tract of property conveyed to Grantor and recorded as Quit Claim Deed KU 2551 in the Shelby County Register's Office and also being the Lot No. 1 and Lot No. 2 of Phase 6, Trails of Arlington, P.D. as recorded in P.B. 236, Page 23 in the Shelby County Register's Office.

THIS DEED IS BEING RE-RECORDED FOR THE SOLE PURPOSE OF CORRECTING INVALID NOTARY ACKNOWLEDGEMENTS in Quit Claim Deed of record as Instrument Number 09045175 in the Shelby County Register's Office.

TO HAVE AND TO HOLD the aforesaid real estate together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said Grantee and assigns in fee simple forever.

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

No abstract or survey furnished for preparation of this instrument.

The preparer of this deed makes no representation as to the status of title to the property described hereto. This deed has been prepared solely from information furnished to the preparer, who makes no representation whatsoever other than it has been accurately transcribed from the information provided.

IN TESTIMONY WHEREOF, this instrument has been executed this 30th day of April, 2009 by the undersigned.

T. DAVID GOODWIN, JR.

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared **T. DAVID GOODWIN, JR.** to me known to be the persons described in and who executed the foregoing instrument, and acknowledged that they executed the same as a free act and deed.

WITNESS my hand and Notarial Seal at office this 30th day of April, 2009.

NOTARY PUBLIC

JANET HILL STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My Commission Expires: _____

My Comm. Exp. 7-17-2012

THIS TRANSFER IS EXEMPT FROM THE PAYMENT OF ANY TRANSFER TAX AS PROVIDED IN T.C.A. 67-4-409(a)(4).

STATE OF TENNESSEE
COUNTY OF SHELBY

I hereby swear or affirm that to the best of affiant's knowledge, information and belief, the actual consideration for this transfer is Ten Dollars ($10.00).

AFFIANT

Subscribed and sworn to before me this 30th day of April, 2009.

NOTARY PUBLIC

JANET HILL STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My Commission Expires: _____

My Comm. Exp. 7-17-2012

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

09073957

06/23/2009 - 11:59 AM

3 PGS	
LIE 662329-9073957	
VALUE	10.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	17.00

TOM LEATHERWOOD
REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

GM

Prepared by & return to: Fearnley & Califf, PLLC, Attorneys, 6389 Quail Hollow, Suite 202, Memphis, TN 38120

QUIT CLAIM DEED

KNOW ALL MEN BY THESE PRESENTS, That T. DAVID GOODWIN, SR, for and in consideration of ONE DOLLAR and other good and valuable consideration, do hereby bargain, sell, remise, release, quit claim and convey unto TDG Investments, LLC a Wyoming Close Limited Liability Company, the following described property located in, Shelby County, Tennessee, to-wit:

See attached Exhibit ``A'' incorporated herein by reference.

Parcel no's: A01 52 00266, A01 52 00267, and A01 52 00230

IN TESTIMONY WHEREOF, we have hereunto set our hands and seals this 4rth day of June, 2009.

T. DAVID GOODWIN, SR.

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, the undersigned Notary Public of the State and County aforesaid, personally appeared T. DAVID GOODWIN, SR., with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged to be the person who executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal at office this 4rth day of June, 2009.

NOTARY PUBLIC

My Commission Expires: 8/8/2012

W. GRADY McDONALD
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF SHELBY
MY COMM. EXP. AUGUST 08, 2012

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Property known as: Vacant Land

Mail Tax Notice to: T. David Goodwin, Sr.
6104 Macon Road
Memphis, TN. 38134

Property owner
and address: TDG Investments, LLC
6104 Macon Road
Memphis, TN. 38134

I, or we, hereby swear or affirm that to the best of affiants knowledge, information, and belief, the actual consideration for this transfer is $ 10.00.

Affiant

Subscribed and sworn to before me this the 4rth day of June, 2009.

Notary Public

My Commission Expires: 8/8/2012

W. GRADY McDONALD
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF SHELBY
MY COMM. EXP. AUGUST 08, 2012

SUPPLEMENTAL #2

January 31, 2017

3:18 pm

Exhibit "A"

TRACT ONE

Proposed Area "C", (S-C), being part of 106.5695 Ac. Tract of property as recorded in Warranty Deed JB -0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old ½" iron pipe (found) in the northeast right-of-way of New Airline Road at station 65+57.46, said point being the southeast corner of said Lot 2; Thence northwestwardly along the northeast right-of-way of New Airline Road N. 52d 32' 36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet an angle of 91d 22' 18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d 49' 41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d 07' 52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d 02' 26" E, 593.57 feet to a point; Thence S 86d 24' 00" W, 537.25 feet to an ½" iron pipe (found); Thence N 52d 35' 41" W, along the northeast right-of-way of New Airline Road 78.07 feet to the point of beginning containing 184,875.9 sq. ft or 4.2441 acres.

Being the same property conveyed to T. DAVID GOODWIN, JR by Quit Claim deed of record as Instrument Number KU 2551 in the Register's Office of Shelby County, Tennessee.

TRACT TWO

Lot No. 1 and 2 of, Phase 6, Trails of Arlington, P.D. Beginning at a southwest corner of Lot # 1 of Trails of Arlington P.D., Phase 5, as record in P. B. 224, Page 52, in the Shelby County Register's Office; Thence southwestwardly along the north R.O.W. line of Arlington Trail (68' R.O.W.), S-64d-56'-16"-W, a distance of 156.89' to a point of curvature; Thence along the curve to the left having a radius of 1171' and an arc distance of 432.30' to the point of tangency; Thence continuing southwestwardly along the said R.O.W. on a relative bearing of S43d-47'-09"-W, a distance of 228.47' to the point of curvature; Thence along the curve to the right having a radius of 35' and an arc distance of 56.57' to the point of combined curve; Thence along the curve to the right having the radius of 1807.86' and an arc distance of 355.46' being also along the east R.O.W. line of New Airline Road (150' R.O.W.) to the point of curvature; Thence continuing northwestwardly along the said R.O.W. on a relative bearing of N-32d-19'-56"-W, a distance of 45.45' to a point; Thence leaving the said R.O.W. along the south line of Lot #1 Re-subdivision of Parcel III, Bond Motor Company (P.B. 161, Pg. 27) on a relative bearing of N-57d-40"-04"-E, a distance of 287.84' to a point; Thence N-32d-19'-56"-W, a distance of 289.59' to the south R.O.W. line of U.S. Interstate I-40; thence northeastwardly along the south line of said R.O.W., on a relative bearing of N-37d-21'08"-E, a distance of 287.61' to a point; Thence continuing along the said R.O.W. on a relative bearing of N-50d-46'-37"-E, a distance of 233.49' to a point; Thence leaving the said R.O.W. along the west line of Lot #1 of Trails of Arlington P.D., Phase 1 (P.B. 203, Page 14) on a relative bearing of S-00d-45'28"-W, a distance of 317-84' to a point; Thence along the south line of said Lot #1 on a relative bearing of N-77d-47'-09"-E, a distance of 340.00' to a point; Thence southeastwardly along the west line of Lot#1 of Trails of Arlington P.D., Phase 5 (P.B. 224, Pg. 52) on a relative bearing of S-25d-03'-44"-E, a distance of 402.47' to the point of beginning, containing 492,905.49 sq. feet or 11.3156 acres.

Being part of 106.5895 ac. Tract of property conveyed to Grantor and recorded as Quit Claim Deed KU 2551 in the Shelby County Register's Office and also being the Lot No. 1 and Lot No. 2 of Phase 6, Trails of Arlington, P.D. as recorded in P.B. 236, Page 23 in the Shelby County Register's Office.

Tom Leatherwood, Shelby County Register of Deeds: Instr # KU2551

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

This Instrument Prepared By:
~~and Return To:~~
WILLIAM L. HAGAN, III
356 NEW BYHALIA RD. SUITE 4
COLLIERVILLE, TN 38017

Return to:
James C. Warner
100 Poplar, Ste 340
Memphis, TN 38119

6

QUIT CLAIM DEED

THIS INDENTURE made and entered into as of the 19th day of November, 1999, by and between **CROSSMANN COMMUNITIES OF TENNESSEE, L.L.C.**, a Tennessee limited liability company, Party of the First Part, and **T. DAVID GOODWIN, SR., T. DAVID GOODWIN, JR.** and **HYNEMAN HOLDINGS, LLC**, a Tennessee limited liability company, collectively, Parties of the Second Part.

W I T N E S S E T H:

THAT, in consideration of Ten and No/100 Dollars ($10.00), Party of the First Part does hereby bargain, sell, remise, release, quitclaim and convey unto Parties of the Second Part, as tenants in common the following: to T. DAVID GOODWIN, SR. an undivided forty percent (40%) interest; to T. DAVID GOODWIN, JR. an undivided forty percent (40%) and to HYNEMAN HOLDINGS, LLC an undivided twenty percent (20%) in and to the parcels of real estate situated and being in the County of Shelby, State of Tennessee, more particularly described on Exhibit "A" attached hereto and incorporated herein by reference.

Party of the First Part reserves for itself, its successors and assigns a right of way to develop, construct and erect a proposed roadway (84' ROW) ("Proposed Road"), as shown on boundary survey prepared by Consulting Engineers Services, LLC, attached hereto as Exhibit "B" and incorporated herein by reference, together with (i) a temporary construction easement (the "Temporary Proposed Road Easement") to include such property located within thirty-five (35) feet on each side of the Proposed Road, and (ii) a temporary construction easement along the thirty-five (35) feet fronting New Airline Road (the "Temporary New Airline Road Easement"). Both the Temporary Proposed Road Easement and the Temporary New Airline Road Easement shall include the right of ingress and egress to and from the Proposed Road, for the purpose of laying, erecting, maintaining and operating over, through and upon the same such pipe lines, sewer and utility lines as may be required to construct Proposed Road, to develop that certain property described in Warranty Deed of record at Instrument No. JB 0083 in the Register's Office of Shelby County, Tennessee, and to comply with the Trails of Arlington Development Agreement and any other requirements of appropriate governmental authorities. The Temporary Proposed Road Easement and the Temporary New Airline Road Easement shall remain in place until the earlier of the completion of such Proposed Road or five (5) years from the date of this conveyance.

It is understood and agreed that said easement is reserved upon the express understanding and condition that Party of the First Part, its successors and assigns, assumes no liability or responsibility to Parties of the Second Part, their respective heirs, successors and assigns, or any person using said roadway by invitation, expressed or implied, or by reason of any business conducted with Parties of the Second Part, their respective heirs, successors or assigns, or otherwise.

Tom Leatherwood, Shelby County Register of Deeds: Instr # KU2551

January 31, 2017
3:18 pm

IN TESTIMONY WHEREOF, we have executed this instrument as of the day and year first above written.

CROSSMANN COMMUNITIES OF TENNESSEE, L.L.C., a Tennessee limited liability company

By: _____

Title: V.P.

STATE OF TENNESSEE
COUNTY OF SHELBY

BEFORE ME, a Notary Public within and for the State and County aforesaid, duly commissioned and qualified, personally appeared _____ to me known to be the person described in and who executed the foregoing instrument, and acknowledged that he executed the same for the purposes therein contained.

WITNESS my hand and official seal on this ___ day of November, 1999.

_____
Notary Public

My Commission Expires:

_____

I hereby swear or affirm that to the best of affiant's knowledge, information and belief, the actual consideration for this transfer is [redacted]. $10.00

_____

Subscribed and sworn to before me this the 12th day of [redacted]. January, 2001.

_____
Notary Public

My Commission Expires:
April 30, 2003

JAMES C. WARNER NOTARY PUBLIC AT LARGE SHELBY COUNTY, TN

Owner of Property and Send Tax Bills To:
T. David Goodwin, Sr., et al
6112 Macon Rd.
Memphis, TN 38134

Property Address:
Vacant Land
East Side Airline Road
South of I-40
Shelby County, Tennessee

Tax Parcel:
Part of Parcels
Nos. A01-52-214
and
A01-52-9

Tom Leatherwood, Shelby County Register of Deeds: Instr # KU2551

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, the undersigned Notary Public in the State and County aforesaid, personally appeared Mark Livingston, with whom I am personally (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be the Vice President of Crossman Communities of Tennessee, LLC, the within named bargainor, a Limited Liability Company and that he as such Vice President, executed the foregoing instrument for the purposes therein contained.

Witness my hand and seal, this 19th day of November, 1999.

My Commission Expires: 1/19/2000

Notary Public

H. RAY BELILES
NOTARY PUBLIC AT LARGE
SHELBY COUNTY, TENNESSEE

Tom Leatherwood, Shelby County Register of Deeds: Instr # KU2551

January 31, 2017
3:18 pm

EXHIBIT A

Description
Of

Proposed Area "C", (S-C), being part of 106.5695 Ac. tract of property as recorded in Warranty Deed JB-0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old 1/2" iron pipe(found) in the northeast right-of-way of New Airline road at station 65+57.46, said point being the southeast corner of said lot 2; Thence northwestwardly along the northeast right-of-way of New Airline road N 52d32'36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet, an angle of 91d22'18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d49'41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d07'52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d02'26" E, 593.57 feet to a point; Thence S 86d24'00" W, 537.25 feet to an 1/2" iron pipe(found); Thence N 52d35'41" W, along the northeast right-of-way of New Airline road 78.07 feet to the point of beginning containing 184,875.9 Sq.ft or 4.2441 acres.

Description
Of

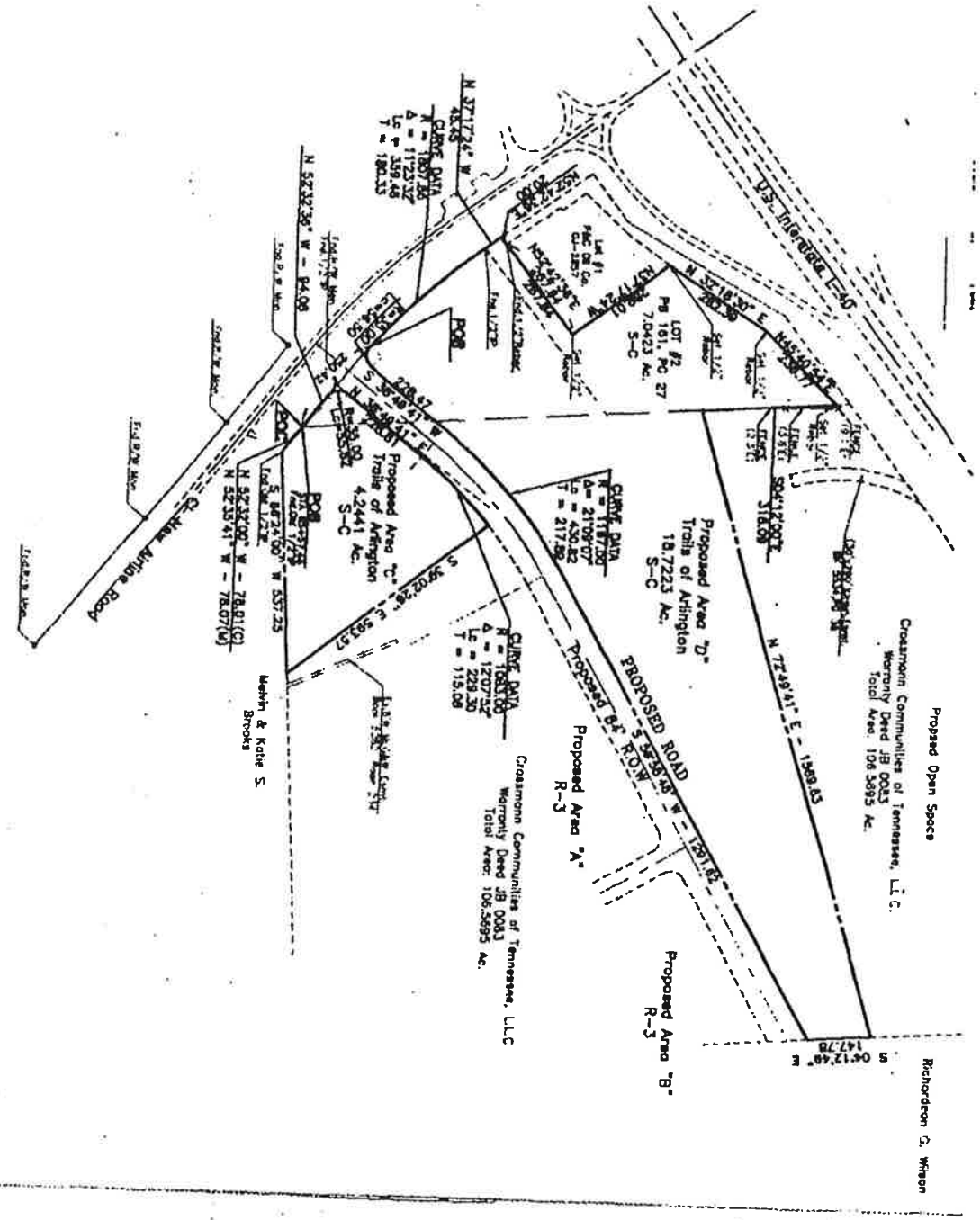
Proposed Area "D", (S-C), being part of 106.5695 Ac. tract of property as recorded in Warranty Deed JB 0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Commencing at an old 1/2" iron pipe(found) in the northeast right-of-way of New Airline road at station 65+57.46, said point being the southeast corner of said lot 2; Thence northwestwardly along the northeast right-of-way of New Airline road 250.42 feet to the Point of Beginning; Thence along a curve to the right, having a radius of 1807.86 feet, an angle of 11d23'32", and an arc length of 359.46 feet to a 1/2" iron pipe(found); Thence N 37d17'24" W, 45.45 feet to a point; Thence N 52d42'36" E, 20.00 feet to an old 1/2" iron pipe(found); Thence N 52d42'36" E, along the southeast line of lot 1 of said subdivision 267.84 feet to a 1/2" re-bar(set); Thence N 37d17'24" W, along the east line of lot 1 a distance of 289.01 feet to a 1/2" re-bar(set); Thence N 32d18'30" E along the southeast right-of-way of Interstate 40 right-of-way 282.39 feet to a 1/2" re-bar(set); Thence continuing along said right-of-way N 45d40'54" E, 238.77 feet to a 1/2" re-bar(set); Thence leaving the right-of-way S 04d12'00" E, along the west line of Beatrice S. Johnson 106.5695 acre tract 318.09 feet to a point; Thence N 72d49'41" E, 1569.63 feet to a point; Thence S 04d12'49" E, 147.78 feet to a point in north line of Proposed 84' R.O.W.; Thence continuing along said Proposed R.O.W. S 59d58'48" W, 1291.62 feet to a point of curvature; Thence continuing along said Proposed R.O.W. with a curve to the left having a radius of 1167.00 feet, an angle of 21d09'07", and arc length of 430.82 feet to a point of tangency; Thence continuing along said Proposed R.O.W. S 38d49'41" W, 228.47 feet to a point of curvature; Thence along a curve to the right having a radius of 35.00 feet, an angle of 92d29'21", and arc length of 56.50 feet to the point of beginning containing 815,544.6 Sq.ft or 18.7223 acres.

Tom Leatherwood, Shelby County Register of Deeds: Instr # KU2551

January 31, 2017
3:18 pm

EXHIBIT B



Tom Leatherwood, Shelby County Register of Deeds: Instr # KU2551

January 31, 2017
3:18 pm

KU2551
01/12/2001-16:05:06

Title Transfer: Quit Claim Deed	13
B/C: 4 - JERRY HERMANN	
VALUATION	N/A
TN MORTGAGE TAX	N/A
TN TRANSFER TAX	N/A
RECORDING FEE	24.00
DP FEE	2.00
REGISTER'S FEE	N/A
WALK THRU FEE	N/A
TOTAL AMOUNT	26.00
PAGE COUNT: 6	PAGE ADDED: No GROUP ID: X00031197

STATE of TENNESSEE, COUNTY of SHELBY
Tom Leatherwood, REGISTER

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

09045174

04/17/2009 - 04:07 PM

3 POS	
LIZ 644807-9045174	
VALUE	
MORTGAGE TAX	10.00
TRANSFER TAX	0.00
RECORDING FEE	0.00
DP FEE	15.00
REGISTER'S FEE	2.00
WALK THRU FEE	0.00
TOTAL AMOUNT	0.00
	17.00

TOM LEATHERWOOD
REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Prepared By and Return To:
Lindsay A. Jones, Esq.
WISEMAN BRAY PLLC
1665 Bonnie Lane, Suite 106
Memphis, Tennessee 38016
(901) 372-5003

Tax Parcels A0152 00266
A0152 00267
A0152 00230

QUIT CLAIM DEED

Property Address & New Owner :	*	Mail Tax Statement to:
TRAILS, LLC	*	TRAILS, LLC
Vacant Land	*	6112 Macon Road
Arlington, TN 38002	*	Memphis, TN 38134

The GRANTOR, **SUSAN PAYNE, TRUSTEE OF THE T. DAVID GOODWIN, JR. IRREVOCABLE TRUST, dated September 10, 2008**, for and in consideration of Ten Dollars ($10.00), cash in hand paid, together with other good, valuable, and satisfactory consideration, the receipt of all of which is hereby acknowledged, does hereby convey and quit claim all of my right, title and interest the below-described property to:

TRAILS, LLC,
A Close Wyoming Limited Liability Company

Said real estate is located in Shelby County, Tennessee and is the same property conveyed to the Grantor by Quit Claim Deed of record as Instrument No. 09036678 in the Shelby County Register's Office and is more particularly described as follows, to-wit:

TRACT ONE

Proposed Area "C", (S-C), being part of 106.5695 Ac. Tract of property as recorded in Warranty Deed JB -0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old ½" iron pipe (found) in the northeast right-of-way of New Airline Road at station 65+57.46, said point being the southeast corner of said Lot 2; Thence northwestwardly along the northeast right-of-way of New Airline Road N. 52d 32' 36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet an angle of 91d 22' 18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d 49' 41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d 07' 52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d 02' 26" E, 593.57 feet to a point; Thence S 86d 24' 00" W, 537.25 feet to an ½" iron pipe (found); Thence N 52d 35' 41" W, along the northeast right-of-way of New Airline Road 78.07 feet to the point of beginning containing 184,875.9 sq. ft or 4.2441 acres.

TRACT TWO

Lot No. 1 and 2 of, Phase 6, Trails of Arlington, P.D. Beginning at a southwest corner of Lot # 1 of Trails of Arlington P.D., Phase 5, as record in P. B. 224, Page 52, in the Shelby County Register's Office; Thence southwestwardly along the north R.O.W. line of Arlington Trail (68' R.O.W.), S-64d-56'-16"-W, a distance of 156.89' to a point of curvature; Thence along the curve to the left having a radius of 1171' and an arc distance of 432.30' to the point of tangency; Thence continuing southwestwardly along the said R.O.W. on a relative bearing of S43d-

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

to the right having a radius of 35' and an arc distance of 56.57' to the point of combined curve; Thence along the curve to the right having the radius of 1807.86' and an arc distance of 355.46' being also along the east R.O.W. line of New Airline Road (150' R.O.W.) to the point of curvature; Thence continuing northwestwardly along the said R.O.W. on a relative bearing of N-32d-19'-56"-W, a distance of 45.45' to a point; Thence leaving the said R.O.W. along the south line of Lot #1 Re-subdivision of Parcel III, Bond Motor Company (P.B. 161, Pg. 27) on a relative bearing of N-57d-40"-04"-E, a distance of 287.84' to a point; Thence N-32d-19'-56"-W, a distance of 289.59' to the south R.O.W. line of U.S. Interstate I-40; thence northeastwardly along the south line of said R.O.W., on a relative bearing of N-37d-21'08"-E, a distance of 287.61' to a point; Thence continuing along the said R.O.W. on a relative bearing of N-50d-46'-37"-E, a distance of 233.49' to a point; Thence leaving the said R.O.W. along the west line of Lot #1 of Trails of Arlington P.D., Phase 1 (P.B. 203, Page 14) on a relative bearing of S-00d-45'28"–W, a distance of 317-84' to a point; Thence along the south line of said Lot #1 on a relative bearing of N-77d-47'-09"-E, a distance of 340.00' to a point; Thence southeastwardly along the west line of Lot#1 of Trails of Arlington P.D., Phase 5 (P.B. 224, Pg. 52) on a relative bearing of S-25d-03'-44"-E, a distance of 402.47' to the point of beginning, containing 492,905.49 sq. feet or 11.3156 acres.

~~Being part of 106.5895 ac. Tract of property conveyed to Grantor and recorded as Quit Claim Deed KU 2551 in the Shelby County Register's Office and also being the Lot No. 1 and Lot No. 2 of Phase 6, Trails of Arlington, P.D. as recorded in P.B. 236, Page 23 in the Shelby County Register's Office.~~

TO HAVE AND TO HOLD the aforesaid real estate together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said Grantee and assigns in fee simple forever.

No abstract or survey furnished for preparation of this instrument.

The preparer of this deed makes no representation as to the status of title to the property described hereto. This deed has been prepared solely from information furnished to the preparer, who makes no representation whatsoever other than it has been accurately transcribed from the information provided.

IN TESTIMONY WHEREOF, this instrument has been executed this 27th day of March,, 2009 by the undersigned.

Susan Payne

SUSAN PAYNE, Trustee of the T. DAVID GOODWIN, JR. IRREVOCABLE TRUST, dated September 10, 2008

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared **SUSAN PAYNE, Trustee of the T. DAVID GOODWIN, JR. IRREVOCABLE TRUST, dated September 10, 2008,** to me known to be the person described in and who executed the foregoing instrument, and acknowledged that she executed the same as a free act and deed.

WITNESS my hand and Notarial Seal at office this 27th day of March, 2009.

Larry R. Bray

NOTARY PUBLIC

LARRY R. BRAY STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY MY COMM. EXP. 3-18-09

My Commission Expires: _____

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

THIS TRANSFER IS EXEMPT FROM THE PAYMENT OF ANY TRANSFER TAX AS PROVIDED IN T.C.A. 67-4-409(a)(4).

STATE OF TENNESSEE
COUNTY OF SHELBY

I hereby swear or affirm that to the best of affiant's knowledge, information and belief, the actual consideration for this transfer is Ten Dollars ($10.00).

Susa Payne
AFFIANT

Subscribed and sworn to before me this 27th day of March, 2009.

Larry R. Bray
NOTARY PUBLIC

My Commission Expires: _____

LARRY R. BRAY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY
MY COMM. EXP. 3-18-09

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

09073958

06/23/2009 - 11:59 AM

3 PGS	
L(T 662329-9073958	
VALUE	10.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	17.00

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

GM

Prepared by & return to: Fearnley & Califf, PLLC, Attorneys, 6389 Quail Hollow, Suite 202, Memphis, TN 38120

QUIT CLAIM DEED

KNOW ALL MEN BY THESE PRESENTS, That T. DAVID GOODWIN, JR. and ELIZABETH G. MCDONALD, Trustees of the T. DAVID GOODWIN, SR. IRREVOCABLE TRUST, dated May 11, 2009, for and in consideration of ONE DOLLAR and other good and valuable consideration, do hereby bargain, sell, remise, release, quit claim and convey all undivided rights, title and interest unto TDG Investments, LLC a Wyoming Close Limited Liability Company, the following described property located in, Shelby County, Tennessee, to-wit:

See attached Exhibit ``A'' incorporated herein by reference.

Parcel no's: A01 52 00266, A01 52 00267, and A01 52 00230

IN TESTIMONY WHEREOF, we have hereunto set our hands and seals this 4rth day of June, 2009.

T. DAVID GOODWIN, JR. and ELIZABETH G. MCDONALD, Trustees of the T. DAVID GOODWIN, SR. IRREVOCABLE TRUST Dated May 11, 2009

T. DAVID GOODWIN, JR., TRUSTEE

ELIZABETH G. MCDONALD, TRUSTEE

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, the undersigned Notary Public of the State and County aforesaid, personally appeared T. DAVID GOODWIN, JR. and ELIZABETH G. MCDONALD, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged to be the persons who executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal at office this 4rth day of June, 2009.

NOTARY PUBLIC

My Commission Expires: 8/8/2012

W. GRADY McDONALD STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF SHELBY MY COMM. EXP. AUGUST 08, 2012

W. GRADY McDONALD STATE OF TENNESSEE COUNTY OF SHELBY MY COMM. EXP. AUGUST 08, 2012

W. GRADY McDONALD STATE OF TENNESSEE COUNTY OF SHELBY MY COMM. EXP. AUGUST 08, 2012

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Property known as: Vacant Land

Mail Tax Notice to: T. David Goodwin, Sr.
6104 Macon Road
Memphis, TN. 38134

Property owner
and address: TDG Investments. LLC
6104 Macon Road
Memphis, TN. 38134

I, or we, hereby swear or affirm that to the best of affiants knowledge, information, and belief, the actual consideration for this transfer is $ 10.00.

Affiant

Subscribed and sworn to before me this the 4rth day of June, 2009.

Notary Public

My Commission Expires: 8/8/2012

W. GRADY McDONALD
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF SHELBY
MY COMM. EXP. AUGUST 08, 2012

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Exhibit "A"

TRACT ONE

Proposed Area "C", (S-C), being part of 106.5695 Ac. Tract of property as recorded in Warranty Deed JB -0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old ½" iron pipe (found) in the northeast right-of-way of New Airline Road at station 65+57.46, said point being the southeast corner of said Lot 2; Thence northwestwardly along the northeast right-of-way of New Airline Road N. 52d 32' 36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet an angle of 91d 22' 18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d 49' 41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d 07' 52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d 02' 26" E, 593.57 feet to a point; Thence S 86d 24' 00" W, 537.25 feet to an ½" iron pipe (found); Thence N 52d 35' 41" W, along the northeast right-of-way of New Airline Road 78.07 feet to the point of beginning containing 184,875.9 sq. ft or 4.2441 acres.

Being the same property conveyed to T. DAVID GOODWIN, JR by Quit Claim deed of record as Instrument Number KU 2551 in the Register's Office of Shelby County, Tennessee.

TRACT TWO

Lot No. 1 and 2 of, Phase 6, Trails of Arlington, P.D. Beginning at a southwest corner of Lot # 1 of Trails of Arlington P.D., Phase 5, as record in P. B. 224, Page 52, in the Shelby County Register's Office; Thence southwestwardly along the north R.O.W. line of Arlington Trail (68' R.O.W.), S-64d-56'-16"-W, a distance of 156.89' to a point of curvature; Thence along the curve to the left having a radius of 1171' and an arc distance of 432.30' to the point of tangency; Thence continuing southwestwardly along the said R.O.W. on a relative bearing of S43d-47'-09"-W, a distance of 228.47' to the point of curvature; Thence along the curve to the right having a radius of 35' and an arc distance of 56.57' to the point of combined curve; Thence along the curve to the right having the radius of 1807.86' and an arc distance of 355.46' being also along the east R.O.W. line of New Airline Road (150' R.O.W.) to the point of curvature; Thence continuing northwestwardly along the said R.O.W. on a relative bearing of N-32d-19'-56"-W, a distance of 45.45' to a point; Thence leaving the said R.O.W. along the south line of Lot #1 Re-subdivision of Parcel III, Bond Motor Company (P.B. 161, Pg. 27) on a relative bearing of N-57d-40"-04"-E, a distance of 287.84' to a point; Thence N-32d-19'-56"-W, a distance of 289.59' to the south R.O.W. line of U.S. Interstate I-40; thence northeastwardly along the south line of said R.O.W., on a relative bearing of N-37d-21'08"-E, a distance of 287.61' to a point; Thence continuing along the said R.O.W. on a relative bearing of N-50d-46'-37"-E, a distance of 233.49' to a point; Thence leaving the said R.O.W. along the west line of Lot #1 of Trails of Arlington P.D., Phase 1 (P.B. 203, Page 14) on a relative bearing of S-00d-45'28"--W, a distance of 317-84' to a point; Thence along the south line of said Lot #1 on a relative bearing of N-77d-47'-09"-E, a distance of 340.00' to a point; Thence southeastwardly along the west line of Lot#1 of Trails of Arlington P.D., Phase 5 (P.B. 224, Pg. 52) on a relative bearing of S-25d-03'-44"-E, a distance of 402.47' to the point of beginning, containing 492,905.49 sq. feet or 11.3156 acres.

Being part of 106.5895 ac. Tract of property conveyed to Grantor and recorded as Quit Claim Deed KU 2551 in the Shelby County Register's Office and also being the Lot No. 1 and Lot No. 2 of Phase 6, Trails of Arlington, P.D. as recorded in P.B. 236, Page 23 in the Shelby County Register's Office.

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

09045175

04/17/2009 - 04:07 PM

3 PGS	
LIK 644807-9045175	
VALUE	10.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	17.00

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Prepared By and Return To:
Lindsay A. Jones, Esq.
WISEMAN BRAY PLLC
1665 Bonnie Lane, Suite 106
Memphis, Tennessee 38016
(901) 372-5003

Tax Parcels A0152 00266
A0152 00267
A0152 00230

QUIT CLAIM DEED

Property Address & New Owner :	*	Mail Tax Statement to:
TRAILS, LLC	*	TRAILS, LLC
6112 Macon Road	*	6112 Macon Road
Memphis, TN 38134	*	Memphis, TN 38134

The GRANTOR, **T. DAVID GOODWIN, JR.**, for and in consideration of Ten Dollars ($10.00), cash in hand paid, together with other good, valuable, and satisfactory consideration, the receipt of all of which is hereby acknowledged, does hereby convey and quit claim all of my right, title and interest in the below-described property to:

TRAILS, LLC,
A Wyoming Close Limited Liability Company

Said real estate is located in Shelby County, Tennessee, and is more particularly described as follows, to-wit:

TRACT ONE

Proposed Area "C", (S-C), being part of 106.5695 Ac. Tract of property as recorded in Warranty Deed JB -0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old ½" iron pipe (found) in the northeast right-of-way of New Airline Road at station 65+57.46, said point being the southeast corner of said Lot 2; Thence northwestwardly along the northeast right-of-way of New Airline Road N. 52d 32' 36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet an angle of 91d 22' 18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d 49' 41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d 07' 52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d 02' 26" E, 593.57 feet to a point; Thence S 86d 24' 00" W, 537.25 feet to an ½" iron pipe (found); Thence N 52d 35' 41" W, along the northeast right-of-way of New Airline Road 78.07 feet to the point of beginning containing 184,875.9 sq. ft or 4.2441 acres.

Being the same property conveyed to T. DAVID GOODWIN, JR by Quit Claim deed of record as Instrument Number KU 2551 in the Register's Office of Shelby County, Tennessee.

TRACT TWO

Lot No. 1 and 2 of, Phase 6, Trails of Arlington, P.D. Beginning at a southwest corner of Lot # 1 of Trails of Arlington P.D., Phase 5, as record in P. B. 224, Page 52, in the Shelby County Register's Office; Thence southwestwardly along the north R.O.W. line of Arlington Trail (68' R.O.W.), S-64d-56'-16"-W, a distance of 156.89' to a point of curvature; Thence along the curve to the left having a radius of 1171' and an arc distance of 432.30' to the point of tangency; Thence continuing southwestwardly along the said R.O.W. on a relative bearing of S43d-47'-09"-W, a distance of 228.47' to the point of curvature; Thence along the curve to the right having a radius of 35' and an arc distance of 56.57' to the point of

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

combined curve; Thence along the curve to the right having the radius of 1807.86' and an arc distance of 355.46' being also along the east R.O.W. line of New Airline Road (150' R.O.W.) to the point of curvature; Thence continuing northwestwardly along the said R.O.W. on a relative bearing of N-32d-19'-56"-W, a distance of 45.45' to a point; Thence leaving the said R.O.W. along the south line of Lot #1 Re-subdivision of Parcel III, Bond Motor Company (P.B. 161, Pg. 27) on a relative bearing of N-57d-40"-04"-E, a distance of 287.84' to a point; Thence N-32d-19'-56"-W, a distance of 289.59' to the south R.O.W. line of U.S. Interstate I-40; thence northeastwardly along the south line of said R.O.W., on a relative bearing of N-37d-21'08"-E, a distance of 287.61' to a point; Thence continuing along the said R.O.W. on a relative bearing of N-50d-46'-37"-E, a distance of 233.49' to a point; Thence leaving the said R.O.W. along the west line of Lot #1 of Trails of Arlington P.D., Phase 1 (P.B. 203, Page 14) on a relative bearing of S-00d-45'28"–W, a distance of 317-84' to a point; Thence along the south line of said Lot #1 on a relative bearing of N-77d-47'-09"-E, a distance of 340.00' to a point; Thence southeastwardly along the west line of Lot#1 of Trails of Arlington P.D., Phase 5 (P.B. 224, Pg. 52) on a relative bearing of S-25d-03'-44"-E, a distance of 402.47' to the point of beginning, containing 492,905.49 sq. feet or 11.3156 acres.

Being part of 106.5895 ac. Tract of property conveyed to Grantor and recorded as Quit Claim Deed KU 2551 in the Shelby County Register's Office and also being the Lot No. 1 and Lot No. 2 of Phase 6, Trails of Arlington, P.D. as recorded in P.B. 236, Page 23 in the Shelby County Register's Office.

TO HAVE AND TO HOLD the aforesaid real estate together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said Grantee and assigns in fee simple forever.

No abstract or survey furnished for preparation of this instrument.

The preparer of this deed makes no representation as to the status of title to the property described hereto. This deed has been prepared solely from information furnished to the preparer, who makes no representation whatsoever other than it has been accurately transcribed from the information provided.

IN TESTIMONY WHEREOF, this instrument has been executed this 27th day of March,, 2009 by the undersigned.

T. DAVID GOODWIN, JR.

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared **T. DAVID GOODWIN, JR.** to me known to be the persons described in and who executed the foregoing instrument, and acknowledged that they executed the same as a free act and deed.

WITNESS my hand and Notarial Seal at office this 27th day of March, 2009.

NOTARY PUBLIC

LARRY R. BRAY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY
MY COMMISSION EXPIRES 2-18-09

My Commission Expires: _____

THIS TRANSFER IS EXEMPT FROM THE PAYMENT OF ANY TRANSFER TAX AS PROVIDED IN T.C.A. 67-4-409(a)(4).

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

STATE OF TENNESSEE
COUNTY OF SHELBY

I hereby swear or affirm that to the best of affiant's knowledge, information and belief, the actual consideration for this transfer is Ten Dollars ($10.00).

AFFIANT

Subscribed and sworn to before me this 27th day of March, 2009.

NOTARY PUBLIC

My Commission Expires: _____

LARRY R. BRAY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY
MY COMM. EXP. 3-18-09

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

09058720

05/19/2009 - 10:58 AM

3 PGS	
LAKECIA 653180-9058720	
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	15.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	17.00

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 ~ (901) 379-7500
Website: http://register.shelby.tn.us ~ Email: Tom.Leatherwood@shelbycountytn.gov

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

Prepared By and Return To:
WISEMAN BRAY PLLC
1665 Bonnie Lane, Suite 106
Memphis, Tennessee 38016
(901) 372-5003

Tax Parcels A0152 00266
A0152 00267
A0152 00230

CORRECTED QUIT CLAIM DEED

Property Address & New Owner :	*	Mail Tax Statement to:
TRAILS, LLC	*	TRAILS, LLC
Vacant Land	*	6112 Macon Road
Arlington, TN 38002	*	Memphis, TN 38134

The GRANTOR, **SUSAN PAYNE, TRUSTEE OF THE T. DAVID GOODWIN, JR. IRREVOCABLE TRUST, dated September 10, 2008**, for and in consideration of Ten Dollars ($10.00), cash in hand paid, together with other good, valuable, and satisfactory consideration, the receipt of all of which is hereby acknowledged, does hereby convey and quit claim all of my right, title and interest the below-described property to:

TRAILS, LLC,
A Close Wyoming Limited Liability Company

Said real estate is located in Shelby County, Tennessee and is the same property conveyed to the Grantor by Quit Claim Deed of record as Instrument No. 09036678 in the Shelby County Register's Office and is more particularly described as follows, to-wit:

TRACT ONE

Proposed Area "C", (S-C), being part of 106.5695 Ac. Tract of property as recorded in Warranty Deed JB -0083 in the Shelby County Register's Office and part of Lot 2 of the Final Plat of the re-subdivision of Parcel III of the Bond Motor Company Inc. Property (7.0423 Ac.) as recorded in Plat Book 161, Page 27, and also recorded in Warranty Deed JB 2671 in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at an old ½" iron pipe (found) in the northeast right-of-way of New Airline Road at station 65+57.46, said point being the southeast corner of said Lot 2; Thence northwestwardly along the northeast right-of-way of New Airline Road N. 52d 32' 36" W, 94.08 feet to a point of curvature; Thence along a curve to the right, having a radius of 35.00 feet an angle of 91d 22' 18", and an arc length of 55.82 feet to a point of tangency; Thence continuing northeastwardly along south line of Proposed 84' R.O.W. N 38d 49' 41" E, 228.81 feet to a point of tangency; Thence continuing along said Proposed R.O.W. with a curve to the right, having a radius of 1083.00 feet, an angle of 12d 07' 52", and an arc length of 229.30 feet to a point of tangency; Thence leaving said proposed R.O.W. S 39d 02' 26" E,

593.57 feet to a point; Thence S 86d 24' 00" W, 537.25 feet to an ½" iron pipe (found); Thence N 52d 35' 41" W, along the northeast right-of-way of New Airline Road 78.07 feet to the point of beginning containing 184,875.9 sq. ft or 4.2441 acres.

TRACT TWO

Lot No. 1 and 2 of, Phase 6, Trails of Arlington, P.D. Beginning at a southwest corner of Lot # 1 of Trails of Arlington P.D., Phase 5, as record in P. B. 224, Page 52, in the Shelby County Register's Office; Thence southwestwardly along the north R.O.W. line of Arlington Trail (68' R.O.W.), S-64d-56'-16"-W, a distance of 156.89' to a point of curvature; Thence along the curve to the left having a radius of 1171' and an arc distance of 432.30' to the point of tangency; Thence continuing southwestwardly along the said R.O.W. on a relative bearing of S43d-47'-09"-W, a distance of 228.47' to the point of curvature; Thence along the curve to the right having a radius of 35' and an arc distance of 56.57' to the point of combined curve; Thence along the curve to the right having the radius of 1807.86' and an arc distance of 355.46' being also along the east R.O.W. line of New Airline Road (150' R.O.W.) to the point of curvature; Thence continuing northwestwardly along the said R.O.W. on a relative bearing of N-32d-19'-56"-W, a distance of 45.45' to a point; Thence leaving the said R.O.W. along the south line of Lot #1 Re-subdivision of Parcel III, Bond Motor Company (P.B. 161, Pg. 27) on a relative bearing of N-57d-40"-04"-E, a distance of 287.84' to a point; Thence N-32d-19'-56"-W, a distance of 289.59' to the south R.O.W. line of U.S. Interstate I-40; thence northeastwardly along the south line of said R.O.W., on a relative bearing of N-37d-21'08"-E, a distance of 287.61' to a point; Thence continuing along the said R.O.W. on a relative bearing of N-50d-46'-37"-E, a distance of 233.49' to a point; Thence leaving the said R.O.W. along the west line of Lot #1 of Trails of Arlington P.D., Phase 1 (P.B. 203, Page 14) on a relative bearing of S-00d-45'28"--W, a distance of 317-84' to a point; Thence along the south line of said Lot #1 on a relative bearing of N-77d-47'-09"-E, a distance of 340.00' to a point; Thence southeastwardly along the west line of Lot#1 of Trails of Arlington P.D., Phase 5 (P.B. 224, Pg. 52) on a relative bearing of S-25d-03'-44"-E, a distance of 402.47' to the point of beginning, containing 492,905.49 sq. feet or 11.3156 acres.

THIS DEED IS BEING RE-RECORDED FOR THE SOLE PURPOSE OF CORRECTING INVALID NOTARY ACKNOWLEDGEMENTS in Quit Claim Deed of record as Instrument Number 09045174 in the Shelby County Register's Office.

TO HAVE AND TO HOLD the aforesaid real estate together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said Grantee and assigns in fee simple forever.

No abstract or survey furnished for preparation of this instrument.

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

The preparer of this deed makes no representation as to the status of title to the property described hereto. This deed has been prepared solely from information furnished to the preparer, who makes no representation whatsoever other than it has been accurately transcribed from the information provided.

IN TESTIMONY WHEREOF, this instrument has been executed this 30th day of April, 2009 by the undersigned.

Susan Payne, Trustee

SUSAN PAYNE, Trustee of the T. DAVID GOODWIN, JR. IRREVOCABLE TRUST, dated September 10, 2008

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared **SUSAN PAYNE, Trustee of the T. DAVID GOODWIN, JR. IRREVOCABLE TRUST, dated September 10, 2008,** to me known to be the person described in and who executed the foregoing instrument, and acknowledged that she executed the same as a free act and deed.

WITNESS my hand and Notarial Seal at office this 30th day of April, 2009.

Janet Hill

NOTARY PUBLIC

JANET HILL STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My Commission Expires: _____

My Comm. Exp. 7-17-2012

THIS TRANSFER IS EXEMPT FROM THE PAYMENT OF ANY TRANSFER TAX AS PROVIDED IN T.C.A. 67-4-409(a)(4).

STATE OF TENNESSEE
COUNTY OF SHELBY

I hereby swear or affirm that to the best of affiant's knowledge, information and belief, the actual consideration for this transfer is Ten Dollars ($10.00).

Susan Payne, Trustee

AFFIANT

Subscribed and sworn to before me this 30th day of April, 2009.

Janet Hill

NOTARY PUBLIC

JANET HILL STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My Commission Expires: _____

My Comm. Exp. 7-17-2012

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

Attachment Section B, Need, Item 3

Revised Page 17

38028, 38053 and 38054 (Shelby County), 38060 and 38068 (Fayette County), 38012 and 38069 (Haywood County), and 38049 (Tipton County).

This service area is reasonable because it is based on the existing service area for emergency department visits for SFH-Bartlett. A zip code level map is included as Attachment Section C, Need-3.

Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents SFH-Bartlett	% of total procedures
Fayette	3,043	8%
Haywood	159	.4%
Tipton	2,476	6%
Shelby	34,020	86%
TOTAL	39,698	100%

Service Area Counties	Projected Utilization-County Residents SFH-Bartlett Year 1	% of total procedures
Fayette	4,060	9%
Haywood	390	1%
Tipton	2,719	6%
Shelby	36,629	84%
Total	43,798	100%

Service Area Counties	Projected Utilization-County Residents FSED Project Year 1	% of total procedures
Fayette	1,413	25%
Haywood	314	6%
Tipton	305	5%
Shelby	3,559	64%
Total	5,591	100%

Service Area Counties	Projected Utilization-County Residents FSED Project Year 2	% of total procedures
Fayette	1,760	26%
Haywood	330	5%
Tipton	355	5%
Shelby	4,211	63%
Total	6,656	100%

Response: The applicant projects utilization for the first two years of the FSED as shown above. The applicant expects that at least 20-25% of these visits will be shifted from SFH-Bartlett due to the difference in proximity for the patients to the FSED. The applicant anticipates a difference in the percentage of procedures from each county because the existing SFH-Bartlett ED sees a greater percentage of patients from Shelby County than the FSED is expected to. As the FSED is located approximately 9 miles from SFH-Bartlett, it makes sense that the patients from the Shelby County areas located in closest proximity to SFH-Bartlett will continue to receive emergency services at SFH-Bartlett because it is more convenient than the proposed FSED location. This results in a greater percentage of the patient visits coming from areas farther out from Bartlett, where patients do not currently have the convenient access to emergency services and will welcome a facility located closer to them.

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

Attachment Section B, Economic Feasibility, Item 4

Revised Page 28 - Historical Data Chart for SFH Bartlett

Revised Historical Data Chart for SFH-Bartlett-ED

Revised Projected Data Chart for SFH-Bartlett

Revised Projected Data Chart for SFH-Bartlett-FSED

HISTORICAL DATA CHART
Saint Francis Hospital-Bartlett

X Total Facility
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2013	Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure: ***patient days***)	30,737	33,223	36,676
B.	Revenue from Services to Patients			
	1. Inpatient Services	**$ 339,227,427**	**$ 363,665,285**	**$ 428,902,679**
	2. Outpatient Services	228,099,959	261,262,618	306,150,501
	3. Emergency Services	67,437,140	77,596,583	91,071,396
	4. Other Operating Revenue (Specify) Gift Shop, Cafeteria	530,100	1,805,340	1,660,430
	Gross Operating Revenue	**$ 635,294,626**	**$ 704,329,826**	**$ 827,785,006**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	**$ 512,637,970**	**$ 569,443,726**	**$ 673,335,213**
	2. Provision for Charity Care	315,265	3,686,452	4,552,862
	3. Provisions for Bad Debt	14,803,643	15,839,479	17,425,039
	Total Deductions	**$ 527,756,878**	**$ 588,969,657**	**$ 695,313,114**
NET OPERATING REVENUE		**$ 107,537,748**	**$ 115,360,169**	**$ 132,471,892**
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Direct Patient Care	$ 29,499,272	$ 30,439,487	$ 33,147,192
	b. Non-Patient Care	10,702,694	10,678,713	12,761,215
	2. Physician's Salaries and Wages	0	0	0
	3. Supplies	18,307,492	19,706,664	24,213,739
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	501,840	482,536	785,029
	5. Management Fees:			
	a. Paid to Affiliates	0	0	0
	b. Paid to Non-Affiliates	0	0	0
	6. Other Operating Expenses	$ 22,442,982	$ 25,013,916	$ 26,654,373
	Total Operating Expenses	**$ 81,454,280**	**$ 86,321,316**	**$ 97,561,548**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$ 26,083,468**	**$ 29,038,853**	**$ 34,910,344**
F.	Non-Operating Expenses			
	1. Taxes	$ 2,950,884	$ 4,407,491	$ 5,998,932
	2. Depreciation	5,137,782	5,268,350	7,714,668
	3. Interest	9,773,850	8,659,210	6,621,781
	4. Other Non-Operating Expenses			
	Total Non-Operating Expenses	**$ 17,862,516**	**$ 18,335,051**	**$ 20,335,381**
NET INCOME (LOSS)		**$ 8,220,952**	**$ 10,703,802**	**$ 14,574,963**

Chart Continues Onto Next Page

JAN 31 '17 PM3:20

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

NET INCOME (LOSS)	**$ 8,220,952**	**$ 10,703,802**	**$ 14,574,963**
G. Other Deductions			
1. Annual Principal Debt Repayment	**$**	**$**	**$**
2. Annual Capital Expenditure	6,532,293	3,247,704	315,049
Total Other Deductions	**$ 6,532,293**	**$ 3,247,704**	**$ 315,049**
NET BALANCE	**$ 1,688,659**	**$ 7,456,098**	**$ 14,259,914**
DEPRECIATION	**$ 5,137,782**	**$ 5,268,350**	**$ 7,714,668**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 6,826,441**	**$ 12,724,448**	**$ 21,974,582**

X Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 13,929,782	$ 15,401,987	$ 16,888,188
2. Utilities	1,555,604	1,752,052	1,678,236
3. Repairs and Maintenance	1,977,912	2,148,055	2,333,905
4. Minor Equipment	290,367	290,440	373,290
5. Travel/Dues	324,602	362,326	312,286
6. Advertising	393,912	282,335	269,573
7. Insurance/Property Taxes	3,970,803	4,776,721	4,798,895
Total Other Expenses	**$ 22,442,982**	**$ 25,013,916**	**$ 26,654,373**

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

HISTORICAL DATA CHART ☐ Total Facility
Saint Francis Hospital-Bartlett-ED ☐ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure: visits)	36,001	38,375	42,220
B. Revenue from Services to Patients			
1. Inpatient Services	$	$	$
2. Outpatient Services			
3. Emergency Services	$ 67,437,140	$ 77,596,583	$ 91,071,396
4. Other Operating Revenue (Specify) Gift Shop/Cafeteria	-0-	-0-	-0-
Gross Operating Revenue	**$ 67,437,140**	**$ 77,596,583**	**$ 91,071,396**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	**$ 34,392,941**	**$ 39,574,257**	**$ 46,446,412**
2. Provision for Charity Care	6,743,714	7,759,658	9,107,140
3. Provisions for Bad Debt	7,890,145	9,078,800	10,655,353
Total Deductions	**$ 49,026,801**	**$ 56,412,716**	**$ 66,208,905**
NET OPERATING REVENUE	**$ 18,410,339**	**$ 21,183,867**	**$ 24,862,491**
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	$ 3,203,172	$ 3,447,577	$ 3,359,176
b. Non-Patient Care	150,000	165,000	175,500
2. Physician's Salaries and Wages			
3. Supplies	584,070	579,937	649,010
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
5. Management Fees:			
b. Paid to Affiliates			
b. Paid to Non-Affiliates			
6. Other Operating Expenses	$ 1,083,619	$ 1,748,763	$ 1,781,708
Total Operating Expenses	**$ 5,020,861**	**$ 5,941,277**	**$ 5,965,394**
E. **Earnings Before Interest, Taxes and Depreciation**	**$ 13,389,478**	**$ 15,242,590**	**$ 18,897,097**
F. Non-Operating Expenses			
1. Taxes	**$ 1,472,843**	**$ 1,676,685**	**$ 2,078,681**
2. Depreciation	156,204	160,891	167,327
3. Interest			
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	**$ 1,629,047**	**$ 1,837,576**	**$ 2,246,007**
NET INCOME (LOSS)	**$ 11,760,432**	**$ 13,405,014**	**$ 16,651,090**

Chart Continues Onto Next Page

SUPPLEMENTAL #2

January 31, 2017

3:18 pm

NET INCOME (LOSS)	$ 11,760,432	$ 13,405,014	$ 16,651,090
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure	$ 1,700	$ 17,025	$ 4,350
Total Other Deductions	$ 1,700	$ 17,025	$ 4,350
NET BALANCE	$ 11,758,732	$ 13,387,989	$ 16,646,740
DEPRECIATION	$ 156,204	$ 160,891	$ 167,327
FREE CASH FLOW (Net Balance + Depreciation)	$ 11,914,936	$ 13,548,880	$ 16,814,066

□ Total Facility
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett - ED

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Professional Services Contract	$ 951,382	$ 1,607,215	$ 1,643,101
2. Utilities	71,500	71,500	71,500
3. Repairs/Maintenance	35,453	35,662	26,849
4. Minor Equipment	5,227	3,801	10,287
5. Travel/Dues	614	2,462	50
6. Advertising	15,000	22,500	24,200
7. Insurance/Property Taxes	4,443	5,623	5,721
Total Other Expenses	$ 1,083,619	$ 1,748,763	$ 1,781,708

SUPPLEMENTAL #2

January 31, 2017

3:18 pm

PROJECTED DATA CHART
Saint Francis Hospital-Bartlett

X Total Facility
□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 1	Year 2
A.	Utilization Data (Specify unit of measure: patient days)	34,680	34,884
B.	Revenue from Services to Patients		
	1. Inpatient Services	$ 515,421,125	$ 546,346,393
	2. Outpatient Services	477,907,020	513,714,374
	3. Emergency Services	15,874,322	19,569,476
	4. Other Operating Revenue (Specify) Gift Shop/Cafeteria	580,260	591,285
	Gross Operating Revenue	**$1,009,782,727**	**$1,080,221,528**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$ 834,103,663	$896,888,458
	2. Provision for Charity Care	7,750,637	8,255,905
	3. Provisions for Bad Debt	20,265,864	20,938,305
	Total Deductions	**$ 862,120,164**	**$ 926,082,668**
NET OPERATING REVENUE		$ 147,662,563	$ 154,138,860
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	38,048,400	39,848,522
	b. Non-Patient Care	13,718,130	14,367,154
	2. Physician's Salaries and Wages		
	3. Supplies	25,354,732	26,479,190
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	1,965,549	1,972,806
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	28,914,991	29,873,972
	Total Operating Expenses	**$ 108,001,802**	**$ 112,541,644**
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 39,660,761	$ 41,597,216
F.	Non-Operating Expenses		
	1. Taxes	$ 5,949,114	$ 6,239,582
	2. Depreciation	8,126,499	8,434,154
	3. Interest	6,621,781	6,621,781
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	**$ 20,697,394**	$ 21,295,517
NET INCOME (LOSS)		$ 18,963,367	$ 20,301,699

Chart Continues Onto Next Page

SUPPLEMENTAL #2

January 31, 2017

3:18 pm

NET INCOME (LOSS)	$ 18,963,367	$ 20,301,699
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure	11,000	11,000
Total Other Deductions	**$ 11,000**	**$ 11,000**
NET BALANCE	**$ 18,952,367**	**$ 20,290,699**
DEPRECIATION	**$ 8,126,499**	**$ 8,434,154**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 27,078,866**	**$ 28,724,853**

X☐ Total Facility
☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett

OTHER EXPENSES CATEGORIES	Year 1	Year 2
1. Professional Services Contract	**$ 19,127,788**	**$ 19,723,429**
2. Utilities	1,719,858	1,773,423
3. Repairs/Maintenance	2,467,834	2,544,683
4. Minor Equipment	298,739	308,050
5. Travel/Dues	499,840	515,438
6. Advertising	457,116	471,357
7. Insurance/Property Taxes	4,343,816	4,537,592
Total Other Expenses	**$ 28,914,991**	**$ 29,873,972**

SUPPLEMENTAL #2

January 31, 2017
3:18 pm

PROJECTED DATA CHART
Saint Francis Hospital-Bartlett FSED

Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 1	Year 2
A.	Utilization Data (visits)	5,591	6,656
B.	Revenue from Services to Patients		
	1. Inpatient Services	$0	$0
	2. Outpatient Services	0	0
	3. Emergency Services	$15,874,322	$19,569,476
	4. Other Operating Revenue (Specify)		
	Gross Operating Revenue	**$15,874,322**	**$19,569,476**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$9,984,000	$12,020,000
	2. Provision for Charity Care	914,000	1,090,000
	3. Provisions for Bad Debt	405,000	503,000
	Total Deductions	**$11,303,000**	**$13,613,000**
NET OPERATING REVENUE		$4,571,322	$5,956,476
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	2,437,201	2,522,503
	b. Non-Patient Care	306,176	316,892
	2. Physician's Salaries and Wages	0	0
	3. Supplies	57,807	75,060
	4. Rent		
	a. Paid to Affiliates	0	0
	b. Paid to Non-Affiliates	1,136,723	1,141,790
	5. Management Fees:		
	a. Paid to Affiliates	0	0
	b. Paid to Non-Affiliates	0	0
	6. Other Operating Expenses	892,011	919,605
	Total Operating Expenses	**$ 4,829,918**	**$ 4,975,850**
E.	**Earnings Before Interest, Taxes and Depreciation**	($ 258,596)	$ 981,298
F.	Non-Operating Expenses		
	1. Taxes	$ 0	$ 147,195
	2. Depreciation	245,000	245,000
	3. Interest	0	0
	4. Other Non-Operating Expenses	0	0
	Total Non-Operating Expenses	**$ 245,000**	**$ 392,195**
NET INCOME (LOSS)		($ 503,593)	$ 589,103

Chart Continues Onto Next Page

SUPPLEMENTAL #2

January 31, 2017

3:18 pm

NET INCOME (LOSS)	($ 503,596)	$ 589,103
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ 0	$ 0
2. Annual Capital Expenditure	$ 11,000	$ 11,000
Total Other Deductions	**$ 11,000**	**$ 11,000**
NET BALANCE	**($ 514,596)**	**$ 578,103**
DEPRECIATION	**$ 245,000**	**$ 245,000**
FREE CASH FLOW (Net Balance + Depreciation)	**($ 269,596)**	**$ 823,103**

□ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES
Saint Francis Hospital-Bartlett FSED

OTHER EXPENSES CATEGORIES	Year 1	Year 2
1. Professional Services Contract	**$ 639,251**	**$ 659,262**
2. Utilities	173,760	178,973
3. Repairs/Maintenance	5,000	5,150
4. Minor Equipment	15,000	15,450
5. Travel/Dues	9,000	9,270
6. Advertising	50,000	51,500
7. Insurance/Property Taxes		
Total Other Expenses	**$ 892,011**	**$ 919,605**

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

Attachment Section B, Economic Feasibility, Item 5.A and 6.B

Revised Page 34

Response: The applicant expects to reach the break-even point during the second year of operation, and generate positive cash flow in the second year of operation as well. Included as Attachment C, Economic Feasibility 6-A is the 10-K SEC filing for Tenet, the ultimate parent company of the applicant.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

ER Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	.7273	.7195	.7601	-.05666	.1647
Hospital Year	**2nd Year previous to Current Year**	**1st Year previous to Current Year**	**Current Year**	**Projected Year 1**	**Projected Year 2**
Net Operating Margin Ratio	.2426	.2517	.2635	.2686	.2699

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: The applicant believes the capitalization ratio to be 95% based on the Tenet 10Q for the quarterly period ended September 30, 2016, which is the most recent data available.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: Please see the chart below for the applicant's projected payor mix.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	3,968,581	25.0
TennCare/Medicaid	3,730,466	23.5
Commercial/Other Managed Care	5,476,641	34.5
Self-Pay	1,206,448	7.6
Charity Care	873,088	5.5
Other (Specify) Private/Exchange	619,099	3.9
Total	15,874,322	100

SUPPLEMENTAL #2
January 31, 2017
3:18 pm

JAN 31 1 PM 3:20

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SAINT FRANCIS HOSPITAL-BARTLETT CN1701-004

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31st day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass

NOTARY PUBLIC

My commission expires: January 8, 2019.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

MY COMMISSION EXPIRES:
JANUARY 8, 2019

HF-0043

Revised 7/02

4812-4155-0145.2