

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION**

Washington, DC 20549

Form 10-Q

Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the quarterly period ended March 31, 2020

OR

Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the transition period from _____ to _____
Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

Nevada
(State of Incorporation)

95-2557091
(IRS Employer Identification No.)

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

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

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

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

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months, and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes No

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

Large accelerated filer

Accelerated filer

Non-accelerated filer

Smaller reporting company

Emerging growth company

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

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

At April 30, 2020, there were 104,715,188 shares of the Registrant's common stock outstanding.

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PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
Dollars in Millions
(Unaudited)

	March 31, 2020	December 31, 2019
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 613	\$ 262
Accounts receivable	2,722	2,743
Inventories of supplies, at cost	324	310
Income tax receivable	18	10
Assets held for sale	394	387
Other current assets	1,317	1,369
Total current assets	5,388	5,081
Investments and other assets	2,467	2,369
Deferred income taxes	263	183
Property and equipment, at cost, less accumulated depreciation and amortization (\$5,622 at March 31, 2020 and \$5,498 at December 31, 2019)	6,786	6,878
Goodwill	7,308	7,252
Other intangible assets, at cost, less accumulated amortization (\$1,130 at March 31, 2020 and \$1,092 at December 31, 2019)	1,611	1,602
Total assets	\$ 23,823	\$ 23,365
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	\$ 165	\$ 171
Accounts payable	1,079	1,204
Accrued compensation and benefits	788	877
Professional and general liability reserves	279	330
Accrued interest payable	306	245
Liabilities held for sale	49	44
Other current liabilities	1,429	1,334
Total current liabilities	4,095	4,205
Long-term debt, net of current portion	15,082	14,580
Professional and general liability reserves	638	635
Defined benefit plan obligations	547	560
Deferred income taxes	27	27
Other long-term liabilities	1,405	1,415
Total liabilities	21,794	21,422
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,526	1,506
Equity:		
Shareholders' equity:		
Common stock, \$0.05 par value; authorized 262,500,000 shares; 152,870,875 shares issued at March 31, 2020 and 152,540,815 shares issued at December 31, 2019	7	7
Additional paid-in capital	4,739	4,760
Accumulated other comprehensive loss	(256)	(257)
Accumulated deficit	(2,434)	(2,513)
Common stock in treasury, at cost, 48,342,502 shares at March 31, 2020 and 48,344,195 shares at December 31, 2019	(2,414)	(2,414)
Total shareholders' deficit	(358)	(417)
Noncontrolling interests	861	854
Total equity	503	437
Total liabilities and equity	\$ 23,823	\$ 23,365

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts
(Unaudited)

	Three Months Ended March 31,	
	2020	2019
Net operating revenues	\$ 4,520	\$ 4,545
Equity in earnings of unconsolidated affiliates	28	34
Operating expenses:		
Salaries, wages and benefits	2,187	2,151
Supplies	763	741
Other operating expenses, net	1,013	1,065
Depreciation and amortization	203	208
Impairment and restructuring charges, and acquisition-related costs	55	19
Litigation and investigation costs	2	13
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(2)	1
Operating income	327	381
Interest expense	(243)	(251)
Other non-operating income, net	1	1
Loss from early extinguishment of debt	—	(47)
Income from continuing operations, before income taxes	85	84
Income tax benefit (expense)	75	(20)
Income from continuing operations, before discontinued operations	160	64
Discontinued operations:		
Income (loss) from operations	(1)	10
Income tax expense	—	(2)
Income (loss) from discontinued operations	(1)	8
Net income	159	72
Less: Net income available to noncontrolling interests	66	84
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	\$ 93	\$ (12)
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders		
Income (loss) from continuing operations, net of tax	\$ 94	\$ (20)
Income (loss) from discontinued operations, net of tax	(1)	8
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	\$ 93	\$ (12)
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:		
Basic		
Continuing operations	\$ 0.90	\$ (0.19)
Discontinued operations	(0.01)	0.08
	\$ 0.89	\$ (0.11)
Diluted		
Continuing operations	\$ 0.89	\$ (0.19)
Discontinued operations	(0.01)	0.08
	\$ 0.88	\$ (0.11)
Weighted average shares and dilutive securities outstanding (in thousands):		
Basic	104,353	102,788
Diluted	105,733	102,788

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME
Dollars in Millions
(Unaudited)

	Three Months Ended March 31,	
	2020	2019
Net income	\$ 159	\$ 72
Other comprehensive income:		
Amortization of net actuarial loss included in other non-operating expense, net	2	3
Unrealized gains (losses) on debt securities held as available-for-sale	1	—
Other comprehensive income before income taxes	3	3
Income tax expense related to items of other comprehensive income	(2)	(1)
Total other comprehensive income, net of tax	1	2
Comprehensive net income	160	74
Less: Comprehensive income attributable to noncontrolling interests	66	84
Comprehensive income available (loss attributable) to Tenet Healthcare Corporation common shareholders	\$ 94	\$ (10)

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Dollars in Millions
(Unaudited)

	Three Months Ended March 31,	
	2020	2019
Net income	\$ 159	\$ 72
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	203	208
Deferred income tax (benefit) expense	(79)	22
Stock-based compensation expense	13	11
Impairment and restructuring charges, and acquisition-related costs	55	19
Litigation and investigation costs	2	13
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(2)	1
Loss from early extinguishment of debt	—	47
Equity in earnings of unconsolidated affiliates, net of distributions received	(11)	3
Amortization of debt discount and debt issuance costs	10	11
Pre-tax loss (income) from discontinued operations	1	(10)
Other items, net	2	(7)
Changes in cash from operating assets and liabilities:		
Accounts receivable	14	(158)
Inventories and other current assets	23	(115)
Income taxes	2	9
Accounts payable, accrued expenses and other current liabilities	(144)	(119)
Other long-term liabilities	(51)	37
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	(68)	(32)
Net cash used in operating activities from discontinued operations, excluding income taxes	—	(2)
Net cash provided by operating activities	129	10
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(182)	(192)
Purchases of businesses or joint venture interests, net of cash acquired	(55)	(2)
Proceeds from sales of facilities and other assets — continuing operations	11	41
Proceeds from sales of facilities and other assets — discontinued operations	—	17
Proceeds from sales of marketable securities, long-term investments and other assets	10	4
Purchases of marketable securities and equity investments	(4)	(4)
Other long-term assets	(2)	(2)
Other items, net	18	(1)
Net cash used in investing activities	(204)	(139)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(240)	(495)
Proceeds from borrowings under credit facility	740	685
Repayments of other borrowings	(48)	(1,620)
Proceeds from other borrowings	7	1,507
Debt issuance costs	(1)	(18)
Distributions paid to noncontrolling interests	(76)	(74)
Proceeds from sale of noncontrolling interests	2	4
Purchases of noncontrolling interests	—	(3)
Proceeds from exercise of stock options and employee stock purchase plan	2	1
Other items, net	40	(17)
Net cash provided by (used in) financing activities	426	(30)
Net increase (decrease) in cash and cash equivalents	351	(159)
Cash and cash equivalents at beginning of period	262	411
Cash and cash equivalents at end of period	\$ 613	\$ 252

Supplemental disclosures:

Interest paid, net of capitalized interest	\$	(172)	\$	(158)
Income tax (payments) refunds, net	\$	(3)	\$	9

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as “Tenet,” “we” or “us”) is a diversified healthcare services company headquartered in Dallas, Texas. Through an expansive care network that includes USPI Holding Company, Inc. (“USPI”), at March 31, 2020, we operated 65 hospitals and approximately 510 other healthcare facilities, including surgical hospitals, ambulatory surgery centers, urgent care and imaging centers, and other care sites and clinics. We also operate Conifer Health Solutions, LLC through our Conifer Holdings, Inc. (“Conifer”) subsidiary, which provides revenue cycle management and value-based care services to hospitals, healthcare systems, physician practices, employers and other customers.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2019 (“Annual Report”). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts).

Effective January 1, 2020, we adopted the Financial Accounting Standards Board (“FASB”) Accounting Standards Update (“ASU”) 2016-13, “Financial Instruments—Credit Losses (Topic 326) Measurement of Credit Losses on Financial Instruments” (“ASU 2016-13”) using the modified retrospective transition approach as of the period of adoption. Upon adoption of ASU 2016-13 on January 1, 2020, we recorded a cumulative effect adjustment to increase accumulated deficit by \$14 million.

Certain prior-year amounts have been reclassified to conform to the current year presentation. In the accompanying Condensed Consolidated Statements of Operations, electronic health record incentives have been reclassified to other operating expenses, net, as they are no longer significant enough to present separately. In the accompanying Condensed Consolidated Statements of Cash Flows, purchases of marketable securities have been reclassified from other items, net within cash flows from investing activities to purchases of marketable securities and equity investments. Additionally, our financial statements and corresponding footnotes for prior periods have been recast to reflect retrospective application of the change in accounting principle discussed in the Professional and General Liability Reserves section of this note.

Although the Condensed Consolidated Financial Statements and related notes within this document are unaudited, we believe all adjustments considered necessary for a fair presentation have been included and are of a normal recurring nature. In preparing our financial statements in conformity with accounting principles generally accepted in the United States (“GAAP”), we are required to make estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. 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.

Operating results for the three month period ended March 31, 2020 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: the impact of the novel coronavirus pandemic on our operations, business, financial condition and cash flows; overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; trends in patient accounts receivable collectability and associated implicit price concessions; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; gains (losses) on sales, consolidation and deconsolidation of facilities; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains (losses) from early

extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: changes in federal, state and local healthcare and business regulations, including mandated closures and other operating restrictions; the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; disease hotspots and seasonal cycles of illness; climate and weather conditions; physician recruitment, satisfaction, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; utilization pressure by managed care organizations, as well as managed care contract negotiations or terminations; hospital performance data on quality measures and patient satisfaction, as well as standard charges for services; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and changing consumer behavior, including with respect to the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

Professional and General Liability Reserves

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

In the three months ended March 31, 2020, we changed our method of accounting for our estimated professional and general liability claims. Under the new method of accounting, the liabilities are reported on an undiscounted basis whereas, previously, the liabilities were reported on a discounted basis. We believe that the undiscounted presentation is preferable because it simplifies the accounting for the liabilities, thereby increasing understandability of our financial results and financial condition, is consistent with the manner in which management evaluates our business, and results in an accounting method and financial statement presentation that is consistent with our key peers.

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

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

Condensed Consolidated Balance Sheets:

	Prior to Change in Accounting Principle	Effect of Change in Accounting Principle	As Reported
At March 31, 2020:			
Deferred income taxes	\$ 259	\$ 4	\$ 263
Professional and general liability reserves	\$ 622	\$ 16	\$ 638
Other long-term liabilities	\$ 1,402	\$ 3	\$ 1,405
Accumulated deficit	\$ (2,419)	\$ (15)	\$ (2,434)
	As Reported	Effect of Change in Accounting Principle	As Adjusted
At December 31, 2019:			
Deferred income taxes	\$ 169	\$ 14	\$ 183
Professional and general liability reserves	\$ 585	\$ 50	\$ 635
Other long-term liabilities	\$ 1,405	\$ 10	\$ 1,415
Accumulated deficit	\$ (2,467)	\$ (46)	\$ (2,513)

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

	Prior to Change in Accounting Principle	Effect of Change in Accounting Principle	As Reported
Three months ended March 31, 2020:			
Salaries, wages and benefits	\$ 2,194	\$ (7)	\$ 2,187
Other operating expenses, net	\$ 1,047	\$ (34)	\$ 1,013
Operating income	\$ 286	\$ 41	\$ 327
Income tax benefit	\$ 85	\$ (10)	\$ 75
Net income	\$ 128	\$ 31	\$ 159
Net income from continuing operations available to Tenet Healthcare Corporation common shareholders	\$ 63	\$ 31	\$ 94
Earnings per share available to Tenet Healthcare Corporation common shareholders from continuing operations:			
Basic	\$ 0.60	\$ 0.30	\$ 0.90
Diluted	\$ 0.60	\$ 0.29	\$ 0.89

	As Reported	Effect of Change in Accounting Principle	As Adjusted
Three months ended March 31, 2019:			
Salaries, wages and benefits	\$ 2,153	\$ (2)	\$ 2,151
Other operating expenses, net	\$ 1,073	\$ (8)	\$ 1,065
Operating income	\$ 371	\$ 10	\$ 381
Income tax expense	\$ (17)	\$ (3)	\$ (20)
Net income	\$ 65	\$ 7	\$ 72
Net loss from continuing operations attributable to Tenet Healthcare Corporation common shareholders	\$ (27)	\$ 7	\$ (20)
Loss per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations:			
Basic	\$ (0.26)	\$ 0.07	\$ (0.19)
Diluted	\$ (0.26)	\$ 0.07	\$ (0.19)

Condensed Consolidated Statements of Cash Flows:

	Prior to Change in Accounting Principle	Effect of Change in Accounting Principle	As Reported
Three months ended March 31, 2020:			
Net income	\$ 128	\$ 31	\$ 159
Deferred income tax benefit	\$ (89)	\$ 10	\$ (79)
Accounts payable, accrued expenses and other current liabilities	\$ (103)	\$ (41)	\$ (144)
Net cash provided by operating activities	\$ 129	\$ —	\$ 129

	As Reported	Effect of Change in Accounting Principle	As Adjusted
Three months ended March 31, 2019:			
Net income	\$ 65	\$ 7	\$ 72
Deferred income tax expense	\$ 19	\$ 3	\$ 22
Accounts payable, accrued expenses and other current liabilities	\$ (109)	\$ (10)	\$ (119)
Net cash provided by operating activities	\$ 10	\$ —	\$ 10

Net Operating Revenues

We recognize net operating revenues in the period in which we satisfy our performance obligations under contracts by transferring services to our customers. Net operating revenues are recognized in the amounts we expect to be entitled to, which are the transaction prices allocated for the distinct services. Net operating revenues for our Hospital Operations and other

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

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

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

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 \$613 million and \$262 million at March 31, 2020 and December 31, 2019, respectively. At March 31, 2020 and December 31, 2019, our book overdrafts were \$225 million and \$246 million, respectively, which were classified as accounts payable.

At March 31, 2020 and December 31, 2019, \$152 million and \$176 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries, and \$2 million for both periods of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our health plan-related businesses.

Also at March 31, 2020 and December 31, 2019, we had \$65 million and \$136 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, \$49 million and \$119 million, respectively, were included in accounts payable.

During the three months ended March 31, 2020 and 2019, we recorded non-cancellable finance leases of \$15 million and \$36 million, respectively, and non-cancellable operating leases of \$54 million and \$28 million, respectively.

Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets at March 31, 2020 and December 31, 2019:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At March 31, 2020:			
Capitalized software costs	\$ 1,657	\$ (948)	\$ 709
Trade names	102	—	102
Contracts	877	(98)	779
Other	105	(84)	21
Total	\$ 2,741	\$ (1,130)	\$ 1,611
At December 31, 2019:			
Capitalized software costs	\$ 1,616	\$ (912)	\$ 704
Trade names	102	—	102
Contracts	869	(94)	775
Other	107	(86)	21
Total	\$ 2,694	\$ (1,092)	\$ 1,602

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

	Total	Years Ending					Later Years
		Nine Months Ending	December 31,				
		2020	2021	2022	2023	2024	
Amortization of intangible assets	\$ 928	\$ 118	\$ 129	\$ 114	\$ 103	\$ 87	\$ 377

We recognized amortization expense of \$41 million and \$45 million in the accompanying Condensed Consolidated Statements of Operations for the three months ended March 31, 2020 and 2019, respectively.

Investments in Unconsolidated Affiliates

We control 244 of the facilities within our Ambulatory Care segment and, therefore, consolidate their results. We account for many of the facilities our Ambulatory Care segment operates (107 of 351 at March 31, 2020), as well as additional companies in which our Hospital Operations segment holds ownership interests, under the equity method as investments in unconsolidated affiliates and report only our share of net income as equity in earnings of unconsolidated affiliates in the accompanying Condensed Consolidated Statements of Operations. Summarized financial information for these equity method investees is included in the following table. For investments acquired during the reporting periods, amounts reflect 100% of the investee's results beginning on the date of our acquisition of the investment.

	Three Months Ended March 31,	
	2020	2019
Net operating revenues	\$ 566	\$ 568
Net income	\$ 109	\$ 150
Net income available to the investees	\$ 69	\$ 106

NOTE 2. ACCOUNTS RECEIVABLE

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

	March 31, 2020	December 31, 2019
Continuing operations:		
Patient accounts receivable	\$ 2,521	\$ 2,567
Estimated future recoveries	163	162
Net cost reports and settlements receivable and valuation allowances	37	12
	2,721	2,741
Discontinued operations	1	2
Accounts receivable, net	\$ 2,722	\$ 2,743

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

We had \$257 million and \$284 million of receivables recorded in other current assets and investments and other assets, respectively, and \$126 million and \$65 million of payables recorded in other current liabilities and other long-term liabilities, respectively, in the accompanying Condensed Consolidated Balance Sheet at March 31, 2020 related to California's provider fee program. We had \$316 million and \$213 million of receivables recorded in other current assets and investments and other assets, respectively, and \$115 million and \$57 million of payables recorded in other current liabilities and other long-term liabilities, respectively, in the accompanying Condensed Consolidated Balance Sheet at December 31, 2019 related to California's provider fee program.

We also provide financial assistance through our charity and uninsured discount programs to uninsured patients who are unable to pay for the healthcare services they receive. Our policy is not to pursue collection of amounts determined to qualify for financial assistance; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital

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(“DSH”) payments. These payments are intended to mitigate our cost of uncompensated care. Some states have also developed provider fee or other supplemental payment programs to mitigate the shortfall of Medicaid reimbursement compared to the cost of caring for Medicaid patients.

The following table shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our uninsured and charity patients in the three months ended March 31, 2020 and 2019:

	Three Months Ended March 31,	
	2020	2019
Estimated costs for:		
Uninsured patients	\$ 156	\$ 158
Charity care patients	40	34
Total	<u>\$ 196</u>	<u>\$ 192</u>

NOTE 3. CONTRACT BALANCES

Hospital Operations Segment

Amounts related to services provided to patients for which we have not billed and that do not meet the conditions of unconditional right to payment at the end of the reporting period are contract assets. For our Hospital Operations segment, our contract assets consist primarily of services that we have provided to patients who are still receiving inpatient care in our facilities at the end of the reporting period. Our Hospital Operations segment’s contract assets are included in other current assets in the accompanying Condensed Consolidated Balance Sheet at March 31, 2020. The opening and closing balances of contract assets for our Hospital Operations segment are as follows:

December 31, 2019	\$ 170
March 31, 2020	151
Increase/(decrease)	\$ (19)
December 31, 2018	\$ 169
March 31, 2019	166
Increase/(decrease)	\$ (3)

Approximately 85% of our Hospital Operations segment’s contract assets meet the conditions for unconditional right to payment and are reclassified to patient receivables within 90 days.

Conifer Segment

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

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

	Receivables	Contract Asset – Unbilled Revenue	Contract Liability – Current Deferred Revenue	Contract Liability – Long-Term Deferred Revenue
December 31, 2019	\$ 26	\$ 11	\$ 61	\$ 18
March 31, 2020	23	7	61	17
Increase/(decrease)	\$ (3)	\$ (4)	\$ —	\$ (1)
December 31, 2018	\$ 42	\$ 11	\$ 61	\$ 20
March 31, 2019	90	11	64	20
Increase/(decrease)	\$ 48	\$ —	\$ 3	\$ —

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

The amount of revenue Conifer recognized in the three months ended March 31, 2020 and 2019 that was included in the opening current deferred revenue liability was \$54 million and \$49 million, respectively. This revenue consists primarily of prepayments for those customers who are billed in advance, changes in estimates related to metric-based services, and up-front integration services that are recognized over the services period.

Contract Costs

We have elected to apply the practical expedient provided by FASB Accounting Standards Codification (“ASC”) 340-40-25-4 and expense as incurred the incremental customer contract acquisition costs for contracts in which the amortization period of the asset is one year or less. However, incremental costs incurred to obtain and fulfill customer contracts for which the amortization period of the asset is longer than one year, which consist primarily of Conifer deferred contract setup costs, are capitalized and amortized on a straight-line basis over the lesser of their estimated useful lives or the term of the related contract. In both of the three months ended March 31, 2020 and 2019, we recognized amortization expense of \$1 million. At both March 31, 2020 and December 31, 2019, the unamortized customer contract costs were \$25 million, and are presented as investments and other assets in the accompanying Condensed Consolidated Balance Sheets.

NOTE 4. ASSETS AND LIABILITIES HELD FOR SALE

In the three months ended December 31, 2019, two of our hospitals and other operations in the Memphis area met the criteria to be classified as held for sale. As a result, we have classified these assets totaling \$394 million as “assets held for sale” in current assets and the related liabilities of \$49 million as “liabilities held for sale” in current liabilities in the accompanying Condensed Consolidated Balance Sheet at March 31, 2020.

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

Accounts receivable	\$ 108
Other current assets	26
Investments and other long-term assets	6
Property and equipment	189
Other intangible assets	23
Goodwill	42
Current liabilities	(41)
Long-term liabilities	(8)
Net assets held for sale	\$ 345

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

	Three Months Ended March 31,	
	2020	2019
Significant disposals:		
Income (loss) from continuing operations, before income taxes		
Chicago area (includes a \$6 million loss and a \$7 million loss on sale in the 2020 and 2019 periods, respectively)	\$ (3)	\$ (12)
Total	\$ (3)	\$ (12)
Significant planned divestitures classified as held for sale:		
Income from continuing operations, before income taxes		
Memphis area	\$ 5	\$ 2
Total	\$ 5	\$ 2

NOTE 5. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the three months ended March 31, 2020, we recorded impairment and restructuring charges and acquisition-related costs of \$55 million, consisting of \$54 million of restructuring charges and \$1 million of acquisition-related costs. Restructuring charges consisted of \$10 million of employee severance costs, \$15 million related to our Global Business Center (“GBC”) in the Philippines, \$23 million of charges due to the termination of the USPI management equity plan, \$1 million of contract and lease termination fees, and \$5 million of other restructuring costs. Acquisition-related costs consisted of \$1 million of transaction costs.

During the three months ended March 31, 2019, we recorded impairment and restructuring charges and acquisition-related costs of \$19 million, consisting of \$1 million of impairment charges, \$16 million of restructuring charges and \$2 million of acquisition-related costs. Restructuring charges consisted of \$7 million of employee severance costs, \$1 million of contract and lease termination fees, and \$8 million of other restructuring costs. Acquisition-related costs consisted of \$2 million of transaction costs.

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

At March 31, 2020, our continuing operations consisted of three reportable segments, Hospital Operations, Ambulatory Care and Conifer. Our segments are reporting units used to perform our goodwill impairment analysis.

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

NOTE 6. LONG-TERM DEBT

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

	March 31, 2020	December 31, 2019
Senior unsecured notes:		
8.125% due 2022	\$ 2,800	\$ 2,800
6.750% due 2023	1,872	1,872
7.000% due 2025	478	478
6.875% due 2031	362	362
Senior secured first lien notes:		
4.625% due 2024	1,870	1,870
4.625% due 2024	600	600
4.875% due 2026	2,100	2,100
5.125% due 2027	1,500	1,500
Senior secured second lien notes:		
5.125% due 2025	1,410	1,410
6.250% due 2027	1,500	1,500
Senior secured credit facility due 2024	500	—
Finance leases and mortgage notes	432	445
Unamortized issue costs and note discounts	(177)	(186)
Total long-term debt	15,247	14,751
Less current portion	165	171
Long-term debt, net of current portion	\$ 15,082	\$ 14,580

Credit Agreement

We have a senior secured revolving credit facility that, at March 31, 2020, provided for revolving loans in an aggregate principal amount of up to \$1.5 billion with a \$200 million subfacility for standby letters of credit. At March 31, 2020, we had \$500 million of cash borrowings outstanding under the revolving credit facility subject to a weighted average interest rate of 1.894%, and we had \$1 million of standby letters of credit outstanding. Based on our eligible receivables, \$999 million was available for borrowing under the revolving credit facility at March 31, 2020.

On April 24, 2020, we amended our credit agreement (as amended, the “Credit Agreement”) to, among other things, (i) increase the aggregate revolving credit commitments from \$1.5 billion to \$1.9 billion, subject to borrowing availability, and (ii) increase the advance rate and raise limits on certain eligible accounts receivable in the calculation of the borrowing base, in each case, for an incremental period of 364 days (the “incremental period”).

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

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

Letter of Credit Facility

In March 2020, we amended our letter of credit facility (as amended, the “LC Facility”) to extend the scheduled maturity date of the LC Facility from March 7, 2021 to September 12, 2024 and to increase the aggregate principal amount of standby and documentary letters of credit that from time to time may be issued thereunder from \$180 million to \$200 million. Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership

interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes.

Drawings under any letter of credit issued under the LC Facility that we have not reimbursed within three business days after notice thereof accrue interest at a base rate plus a margin equal to 0.50% per annum. An unused commitment fee is payable at an initial rate of 0.25% per annum with a step up to 0.375% per annum should our secured-debt-to-EBITDA ratio equal or exceed 3.00 to 1.00 at the end of any fiscal quarter. A fee on the aggregate outstanding amount of issued but undrawn letters of credit accrues at a rate of 1.50% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At March 31, 2020, we had \$91 million of standby letters of credit outstanding under the LC Facility.

NOTE 7. GUARANTEES

At March 31, 2020, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was \$187 million. We had a total liability of \$163 million recorded for these guarantees included in other current liabilities at March 31, 2020.

At March 31, 2020, we also had issued guarantees of the indebtedness and other obligations of our investees to third parties, the maximum potential amount of future payments under which was approximately \$25 million. Of the total, \$8 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Condensed Consolidated Balance Sheet at March 31, 2020.

NOTE 8. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

In recent years, we have granted options and restricted stock units to certain of our employees and directors pursuant to our stock incentive plans. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock in the future, and the fair value of the restricted stock unit is based on our share price on the grant date. Typically, options and time-based restricted stock units vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have different vesting terms. In addition, we grant performance-based options and performance-based restricted stock units that vest subject to the achievement of specified performance goals within a specified time frame. At March 31, 2020, assuming outstanding performance-based restricted stock units and options for which performance has not yet been determined will achieve target performance, approximately 6.1 million shares of common stock were available under our 2019 Stock Incentive Plan for future stock option grants and other equity incentive awards, including restricted stock units.

The accompanying Condensed Consolidated Statements of Operations for the three months ended March 31, 2020 and 2019 include \$13 million and \$11 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements.

Stock Options

The following table summarizes stock option activity during the three months ended March 31, 2020:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value	Weighted Average Remaining Life
(In Millions)				
Outstanding at December 31, 2019	1,960,992	\$ 20.24		
Exercised	(27,167)	19.54		
Outstanding at March 31, 2020	1,933,825	\$ 20.25	\$ —	5.9 years
Vested and expected to vest at March 31, 2020	1,933,825	\$ 20.25	\$ —	5.9 years
Exercisable at March 31, 2020	1,242,956	\$ 18.34	\$ —	4.9 years

There were 27,167 and 76,159 stock options exercised during the three months ended March 31, 2020 and 2019, respectively, with aggregate intrinsic values of less than \$1 million in both periods.

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At March 31, 2020, there were \$3 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 1.4 years.

On March 29, 2019, we granted an aggregate of 7,862 performance-based stock options to a senior officer. The options will all vest on the third anniversary of the grant date because, in the three months ended March 31, 2020, the requirement that our stock close at a price of at least \$36.05 (a 25% premium above the March 29, 2019 grant-date closing stock price of \$28.84) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date. On February 27, 2019, we granted to certain of our senior officers an aggregate of 222,851 performance-based stock options. The options will all vest on the third anniversary of the grant date because, in the three months ended March 31, 2020, the requirement that our stock close at a price of at least \$35.33 (a 25% premium above the February 27, 2019 grant-date closing stock price of \$28.26) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date.

The weighted average estimated fair value of stock options we granted in the three months ended March 29, 2019 was \$12.50 per share. This fair value was calculated based on each grant date, using a Monte Carlo simulation with the following assumptions:

	March 29, 2019	February 27, 2019
Expected volatility	48%	48%
Expected dividend yield	0%	0%
Expected life	6.2 years	6.2 years
Expected forfeiture rate	0%	0%
Risk-free interest rate	2.26%	2.53%

The expected volatility used for the 2019 Monte Carlo simulations incorporates historical volatility based on an analysis of historical prices of our stock. The expected volatility reflects the historical volatility for a duration consistent with the expected life of the options; it does not consider the implied volatility from open-market exchanged options due to the limited trading activity and the transient nature of factors impacting our stock price volatility. The historical share-price volatility for 2019 excludes the movements in our stock price for the period from August 15, 2017 through November 30, 2017 due to impact that the announcement of the departure of certain board members and officers, as well as speculative reports that we were exploring a potential sale of the company, had on our stock price during that time. The risk-free interest rates are based on zero-coupon U.S. Treasury yields in effect at the date of grant consistent with the expected exercise time frames.

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

Range of Exercise Prices	Options Outstanding			Options Exercisable	
	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
\$16.43 to \$19.759	1,201,289	5.0 years	\$ 18.12	1,201,289	\$ 18.12
\$19.76 to \$35.430	732,536	7.3 years	23.75	41,667	24.83
	1,933,825	5.9 years	\$ 20.25	1,242,956	\$ 18.34

Restricted Stock Units

The following table summarizes restricted stock unit activity during the three months ended March 31, 2020:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2019	1,463,499	\$ 25.08
Granted	1,423,953	29.05
Vested	(394,281)	25.28
Forfeited	(14,587)	24.80
Unvested at March 31, 2020	2,478,584	\$ 27.33

In the three months ended March 31, 2020, we granted an aggregate of 1,423,953 restricted stock units. Of these, 493,929 will vest and be settled ratably over a three-year period from the grant date, 104,167 will vest and be settled ratably over a four-year period from the grant date, and 359,713 will vest and be settled ratably over 11 quarterly periods from the grant date. In addition, we granted 386,016 performance-based restricted stock units; the vesting of these restricted stock units is contingent on our achievement of specified three-year performance goals for the years 2020 to 2022. Provided the goals are

achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 386,016 units granted, depending on our level of achievement with respect to the performance goals. We also granted 80,128 performance-based restricted stock units to a Conifer senior officer; the vesting of these restricted stock units is contingent on Conifer's achievement of specified performance goals for each of the years 2020 to 2023. Provided the goals are achieved, the performance-based restricted stock units will vest and settle ratably over the four-year period from the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 80,128 units granted, depending on Conifer's level of achievement with respect to the performance goals.

In the three months ended March 31, 2019, we granted an aggregate of 1,128,005 restricted stock units. Of these, 243,506 will vest and be settled ratably over a three-year period from the grant date, 566,172 will vest and be settled ratably over nine quarterly periods from the grant date, and 318,327 will vest and be settled on the third anniversary of the grant date.

At March 31, 2020, there were \$48 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.

USPI Management Equity Plan

In February 2020, USPI's previous management equity plan and all unvested options granted under the plan were terminated in accordance with the terms of the plan as previously disclosed. USPI repurchased all vested options and all shares of USPI stock acquired upon exercise of an option for approximately \$35 million. USPI then adopted a new restricted stock plan whereby USPI granted 2,444,049 shares of restricted non-voting common stock to eligible plan participants in the three months ended March 31, 2020. The restricted stock units vest 20% in each of the first three years on the anniversary of the grant date with the remaining 40% vesting on the fourth anniversary of the grant date.

Employee Retirement Plans

In the three months ended March 31, 2020 and 2019, we recognized (i) service cost related to one of our frozen nonqualified defined benefit pension plans of less than \$1 million for both periods in salaries, wages and benefits expense, and (ii) other components of net periodic pension cost and net periodic postretirement benefit cost related to our frozen qualified and nonqualified defined benefit plans of \$2 million and \$5 million, respectively, in other non-operating income (expense), net, in the accompanying Condensed Consolidated Statements of Operations.

NOTE 9. EQUITY

Changes in Shareholders' Equity

The following tables show the changes in consolidated equity during the three months ended March 31, 2020 and 2019 (dollars in millions, share amounts in thousands):

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balances at December 31, 2019	104,197	\$ 7	\$ 4,760	\$ (257)	\$ (2,513)	\$ (2,414)	\$ 854	\$ 437
Net income	—	—	—	—	93	—	32	125
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(40)	(40)
Other comprehensive income	—	—	—	1	—	—	—	1
Accretion of redeemable noncontrolling interests	—	—	(1)	—	—	—	—	(1)
Purchases (sales) of businesses and noncontrolling interests	—	—	(30)	—	—	—	15	(15)
Cumulative effect of accounting change	—	—	—	—	(14)	—	—	(14)
Stock-based compensation expense, tax benefit and issuance of common stock	331	—	10	—	—	—	—	10
Balances at March 31, 2020	104,528	\$ 7	\$ 4,739	\$ (256)	\$ (2,434)	\$ (2,414)	\$ 861	\$ 503

	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balances at December 31, 2018	102,537	\$ 7	\$ 4,747	\$ (223)	\$ (2,299)	\$ (2,414)	\$ 806	\$ 624
Net income (loss)	—	—	—	—	(12)	—	37	25
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(37)	(37)
Other comprehensive income	—	—	—	2	—	—	—	2
Accretion of redeemable noncontrolling interests	—	—	(5)	—	—	—	—	(5)
Purchases (sales) of businesses and noncontrolling interests	—	—	(2)	—	—	—	2	—
Cumulative effect of accounting change	—	—	—	—	1	—	—	1
Stock-based compensation expense, tax benefit and issuance of common stock	543	—	8	—	—	—	—	8
Balances at March 31, 2019	103,080	\$ 7	\$ 4,748	\$ (221)	\$ (2,310)	\$ (2,414)	\$ 808	\$ 618

Our noncontrolling interests balances at March 31, 2020 and December 31, 2019 were comprised of \$116 million and \$114 million, respectively, from our Hospital Operations segment, and \$745 million and \$740 million, respectively, from our Ambulatory Care segment. Our net income available to noncontrolling interests for the three months ended March 31, 2020 and 2019 in the table above were comprised of \$2 million in both periods from our Hospital Operations segment, and \$30 million and \$35 million, respectively, from our Ambulatory Care segment.

NOTE 10. NET OPERATING REVENUES

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

The table below shows our sources of net operating revenues from continuing operations:

	Three Months Ended March 31,	
	2020	2019
Hospital Operations:		
Net patient service revenues from hospitals and related outpatient facilities		
Medicare	\$ 705	\$ 758
Medicaid	281	314
Managed care	2,321	2,354
Uninsured	40	1
Indemnity and other	193	155
Total	3,540	3,582
Other revenues ⁽¹⁾	294	280
Hospital Operations total prior to inter-segment eliminations	3,834	3,862
Ambulatory Care	490	480
Conifer	332	349
Inter-segment eliminations	(136)	(146)
Net operating revenues	\$ 4,520	\$ 4,545

⁽¹⁾ Primarily physician practices revenues.

Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the three months ended March 31, 2020 and 2019 by \$4 million and \$10 million, respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Condensed Consolidated Balance Sheets (see Note 2). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

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

	Three Months Ended March 31,	
	2020	2019
Net patient service revenues	\$ 464	\$ 451
Management fees	21	23
Revenue from other sources	5	6
Net operating revenues	\$ 490	\$ 480

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

	Three Months Ended March 31,	
	2020	2019
Revenue cycle services – Tenet	\$ 134	\$ 142
Revenue cycle services – other customers	176	180
Other services – Tenet	2	4
Other services – other customers	20	23
Net operating revenues	\$ 332	\$ 349

Other services represent approximately 7% of Conifer’s revenue and include value-based care services, consulting services and other client-defined projects.

Performance Obligations

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

	Total	Nine Months Ending	Years Ending					Later Years
		December 31,						
		2020	2021	2022	2023	2024		
Performance obligations	\$ 7,366	\$ 463	\$ 614	\$ 614	\$ 614	\$ 614	\$ 562	\$ 4,499

NOTE 11. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

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

Professional and General Liability Reserves

We are self-insured for the majority of our professional and general liability claims and purchase insurance from third-parties to cover catastrophic claims. At March 31, 2020 and December 31, 2019, the aggregate current and long-term professional and general liability reserves in the accompanying Condensed Consolidated Balance Sheets were \$917 million and \$965 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. As discussed in Note 1, in the three months ended March 31, 2020, we changed our method of accounting for our estimated professional and general liability claims, as well as other claims-related liabilities. Under the new method of accounting, the liabilities are reported on an undiscounted basis whereas, previously, the liabilities were reported on a discounted basis.

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

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of \$73 million and \$113 million for the three months ended March 31, 2020 and 2019, respectively.

NOTE 12. CLAIMS AND LAWSUITS

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

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

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

Shareholder Derivative Litigation

In January 2017, the Dallas County District Court consolidated two previously disclosed shareholder derivative lawsuits filed on behalf of the Company by purported shareholders of the Company’s common stock against current and former officers and directors into a single matter captioned *In re Tenet Healthcare Corporation Shareholder Derivative Litigation*. The plaintiffs filed a consolidated shareholder derivative petition in February 2017. The consolidated shareholder derivative petition alleged that false or misleading statements or omissions concerning the Company’s financial performance and compliance policies, specifically with respect to the previously disclosed civil qui tam litigation and parallel criminal investigation of the Company and certain of its subsidiaries (together, the “Clinica de la Mama matters”), caused the price of the Company’s common stock to be artificially inflated. In addition, the plaintiffs alleged that the defendants violated GAAP by failing to disclose an estimate of the possible loss or a range of loss related to the Clinica de la Mama matters. The plaintiffs claimed that they did not make demand on the Company’s board of directors to bring the lawsuit because such a demand would have been

futile. In May 2018, the judge in the consolidated shareholder derivative litigation entered an order lifting the previous year-long stay of the matter and, in July 2018, the defendants filed pleadings seeking dismissal of the lawsuit. In October 2018, the judge granted defendants' motion to dismiss, but also agreed to give the plaintiffs 30 days to replead their complaint. In January 2019, the court issued a final judgment and order of dismissal after the plaintiffs elected not to replead. In February 2019, the plaintiffs filed an appeal of the court's ruling that dismissal was appropriate because the plaintiffs failed to adequately plead that a pre-suit demand on the Company's board of directors, a precondition to their action, should be excused as futile. The parties' appellate briefs have been filed, and oral arguments were held on February 5, 2020. The parties are awaiting the court's ruling. The defendants intend to continue to vigorously contest the plaintiffs' allegations in this matter.

Government Investigation of Detroit Medical Center

Detroit Medical Center ("DMC") is subject to an ongoing investigation by the U.S. Attorney's Office for the Eastern District of Michigan and the U.S. Department of Justice ("DOJ") for potential violations of the Stark law, the Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute"), and the federal False Claims Act ("FCA") related to DMC's employment of nurse practitioners and physician assistants ("Mid-Level Practitioners") from 2006 through 2017. As previously disclosed, a media report was published in August 2017 alleging that 14 Mid-Level Practitioners were terminated by DMC earlier in 2017 due to compliance concerns. We are cooperating with the investigation and continue to produce documents on a schedule agreed upon with the DOJ. Because the government's review is in its preliminary stages, we are unable to determine the potential exposure, if any, at this time.

Oklahoma Surgical Hospital Qui Tam Action

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

Pursuant to the obligations under our NPA, we reported the unsealed qui tam action to the DOJ and began investigating the claims contained in the amended complaint and cooperating fully with the DOJ. We began discussing potential resolution of these matters with the DOJ and the Office of Inspector General of the U.S. Department of Health and Human Services ("OIG") during the three months ended September 30, 2019.

In October 2019, an agreement in principle was reached with the DOJ to resolve the qui tam lawsuit and related investigations against USPI and OCOM for approximately \$66 million, subject to further approvals by the DOJ and other government agencies. In the three months ended September 30, 2019, we established a reserve of \$68 million for this matter, which includes an estimate of the relator's attorney's fees and certain other costs to be paid by USPI. In the three months ended December 31, 2019, we increased the reserve for this matter by an additional \$1 million to reflect updated information on the other costs to be paid by USPI. Any final resolution remains subject to negotiation and final approval of a settlement agreement with the DOJ and any other definitive documentation required by OIG or other government agencies. We believe this could be completed as early as the second quarter of 2020, at which time the monetary component of the resolution would be paid by USPI.

Other Matters

On July 1, 2019, certain of the entities that purchased the operations of Hahnemann University Hospital and St. Christopher's Hospital for Children in Philadelphia from us commenced Chapter 11 bankruptcy proceedings. As previously disclosed in our Form 8-K filed September 1, 2017, the purchasers assumed our funding obligations under the Pension Fund for Hospital and Health Care Employees of Philadelphia and Vicinity (the "Fund"), a pension plan related to the operations at Hahnemann University Hospital and, pursuant to rules under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), under certain circumstances we could become liable for withdrawal liability in the event a withdrawal is triggered with respect to the Fund. In July 2019, the Fund notified us of a withdrawal liability assessment of approximately \$63 million. In February 2020, the Fund notified us that the prior assessment against us had been withdrawn. As previously

disclosed, pursuant to applicable ERISA rules, we could become secondarily liable if the purchasers fail to satisfy their obligations to the Fund.

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

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

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

	Balances at Beginning of Period		Litigation and Investigation Costs		Cash Payments		Balances at End of Period
Three Months Ended March 31, 2020	\$ 86	\$	2	\$	(2)	\$	86
Three Months Ended March 31, 2019	\$ 8	\$	13	\$	(8)	\$	13

For the three months ended March 31, 2020 and 2019, we recorded costs of \$2 million and \$13 million, respectively, in continuing operations in connection with significant legal proceedings and governmental investigations.

NOTE 13. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the three months ended March 31, 2020 and 2019:

	Three Months Ended March 31,	
	2020	2019
Balances at beginning of period	\$ 1,506	\$ 1,420
Net income	34	47
Distributions paid to noncontrolling interests	(36)	(37)
Accretion of redeemable noncontrolling interests	1	5
Purchases and sales of businesses and noncontrolling interests, net	21	4
Balances at end of period	\$ 1,526	\$ 1,439

The following tables show the composition by segment of our redeemable noncontrolling interests balances at March 31, 2020 and December 31, 2019, as well as our net income available to redeemable noncontrolling interests for the three months ended March 31, 2020 and 2019:

	March 31, 2020	December 31, 2019
Hospital Operations	\$ 380	\$ 383
Ambulatory Care	784	777
Conifer	362	346
Redeemable noncontrolling interests	\$ 1,526	\$ 1,506

	Three Months Ended March 31,	
	2020	2019
Hospital Operations	\$ (9)	\$ (6)
Ambulatory Care	27	33
Conifer	16	20
Net income available to redeemable noncontrolling interests	\$ 34	\$ 47

NOTE 14. INCOME TAXES

During the three months ended March 31, 2020, we recorded an income tax benefit of \$75 million in continuing operations on pre-tax income of \$85 million compared to income tax expense of \$20 million on pre-tax income of \$84 million during the three months ended March 31, 2019. For the three months ended March 31, 2020, we utilized the discrete effective tax rate method, as allowed by the FASB ASC 740-270-30-18, "Income Taxes—Interim Reporting," to calculate the interim income tax provision. The discrete method is applied when application of the estimated annual effective tax rate is impractical because it is not possible to reliably estimate the annual effective tax rate. The discrete method treats the year-to-date period as if it were the annual period and determines the income tax expense or benefit on that basis. We believe that, at this time, the use of this discrete method is more appropriate than the annual effective tax rate method as the estimated annual effective tax rate method is not reliable due to the high degree of uncertainty in estimating annual pre-tax income due to COVID-19. For the three months ended March 31, 2019, the provision for income taxes was calculated by applying an estimate of the annual effective tax rate for the full year to "ordinary" income or loss (pre-tax income or loss excluding unusual or infrequently occurring discrete items) for the reporting period. In calculating "ordinary" income, non-taxable income or loss attributable to noncontrolling interests was deducted from pre-tax income or loss in the determination of the annualized effective tax rate used to calculate income taxes for the quarter. The reconciliation between the amount of recorded income tax expense and the amount calculated at the statutory federal tax rate is shown in the following table:

	Three Months Ended March 31,	
	2020	2019
Tax expense at statutory federal rate of 21%	\$ 18	\$ 18
State income taxes, net of federal income tax benefit	5	3
Tax attributable to noncontrolling interests	(14)	(17)
Nontaxable gains	3	(1)
Stock-based compensation	—	(1)
Change in valuation allowance	(90)	24
Other items	3	(6)
Income tax expense (benefit)	\$ (75)	\$ 20

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which was signed into law on March 27, 2020, includes a significant number of tax provisions applicable to individuals and businesses. For businesses, the CARES Act makes changes to the U.S. tax code relating to, among other things: (1) the business interest expense disallowance rules for 2019 and 2020; (2) net operating loss rules; (3) charitable contribution limitations; and (4) the realization of corporate alternative minimum tax credits. As a result of the change in the business interest expense disallowance rules, we recorded an income tax benefit of \$91 million to decrease the valuation allowance for interest expense carryforwards due to the additional deduction of interest expense.

During the three months ended March 31, 2020, there were no adjustments to our estimated liabilities for uncertain tax positions. The total amount of unrecognized tax benefits at March 31, 2020 was \$31 million, of which \$29 million, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. There were no accrued interest and penalties on unrecognized tax benefits at March 31, 2020.

At March 31, 2020, no significant changes in unrecognized federal and state tax benefits are expected in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

NOTE 15. EARNINGS (LOSS) PER COMMON SHARE

The following table is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for our continuing operations for three months ended March 31, 2020 and 2019. Net income available (loss attributable) to our common shareholders is expressed in millions and weighted average shares are expressed in thousands.

	Net Income Available (Loss Attributable) to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended March 31, 2020			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	\$ 94	104,353	\$ 0.90
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	1,380	(0.01)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	\$ 94	105,733	\$ 0.89
Three Months Ended March 31, 2019			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	\$ (20)	102,788	\$ (0.19)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	\$ (20)	102,788	\$ (0.19)

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three months ended March 31, 2019 because we did not report income from continuing operations available to common shareholders in that period. In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to common shareholders in the three months ended March 31, 2019, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 1,753.

NOTE 16. FAIR VALUE MEASUREMENTS

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

	March 31, 2020	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held for sale	\$ 394	\$ —	\$ 394	\$ —
	December 31, 2019	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held for sale	\$ 387	\$ —	\$ 387	\$ —

The fair value of our long-term debt (except for borrowings under the Credit Agreement) is based on quoted market prices (Level 1). The inputs used to establish the fair value of the borrowings outstanding under the Credit Agreement are considered to be Level 2 inputs, which include inputs other than quoted prices included in Level 1 that are observable, either directly or indirectly. At March 31, 2020 and December 31, 2019, the estimated fair value of our long-term debt was approximately 95.1% and 106.4%, respectively, of the carrying value of the debt.

NOTE 17. ACQUISITIONS

Preliminary purchase price allocations (representing the fair value of the consideration conveyed) for all acquisitions made during the three months ended March 31, 2020 and 2019 are as follows:

	Three Months Ended March 31,	
	2020	2019
Current assets	\$ 6	\$ 2
Property and equipment	8	5
Other intangible assets	8	1
Goodwill	83	3
Other long-term assets, including previously held equity method investments	5	(1)
Current liabilities	(8)	—
Long-term liabilities	(6)	(1)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(30)	(1)
Noncontrolling interests	(11)	(1)
Cash paid, net of cash acquired	(55)	(2)
Gains on consolidations	\$ —	\$ 5

The goodwill generated from these transactions, the majority of which will be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. The goodwill total of \$83 million from acquisitions completed during the three months ended March 31, 2020 was recorded in our Ambulatory Care segment. Approximately \$1 million and \$2 million in transaction costs related to prospective and closed acquisitions were expensed during the three month periods ended March 31, 2020 and 2019, respectively, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statements of Operations.

We are required to allocate the purchase prices of acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, other intangible assets and noncontrolling interests for some of our 2020 and 2019 acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed.

During the three months ended March 31, 2019, we recognized gains totaling \$5 million associated with stepping up our ownership interests in previously held equity method investments, which we began consolidating after we acquired controlling interests.

NOTE 18. SEGMENT INFORMATION

Our business consists of our Hospital Operations segment, our Ambulatory Care segment and our Conifer segment. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Our Hospital Operations segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. As described in Note 4, certain of these facilities are classified as held for sale in the accompanying Condensed Consolidated Balance Sheet at March 31, 2020. At March 31, 2020, our subsidiaries operated 65 hospitals serving primarily urban and suburban communities in nine states.

Our Ambulatory Care segment is comprised of the operations of USPI. At March 31, 2020, USPI had interests in 265 ambulatory surgery centers, 39 urgent care centers operated under the CareSpot brand, 23 imaging centers and 24 surgical hospitals in 27 states. At March 31, 2020, we owned 95% of USPI.

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Our Conifer segment provides revenue cycle management and value-based care services to hospitals, healthcare systems, physician practices, employers and other customers. At March 31, 2020, Conifer provided services to approximately 660 Tenet and non-Tenet hospitals and other clients nationwide. In 2012, we entered into agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations segment provides to Conifer. The pricing terms for the services provided by each party to the other under these contracts were based on estimated third-party pricing terms in effect at the time the agreements were signed. At March 31, 2020, we owned 76.2% of Conifer Health Solutions, LLC, which is the principal subsidiary of Conifer Holdings, Inc.

The following tables include amounts for each of our reportable segments and the reconciling items necessary to agree to amounts reported in the accompanying Condensed Consolidated Balance Sheets and in the Condensed Consolidated Statements of Operations, as applicable:

	March 31, 2020	December 31, 2019
Assets:		
Hospital Operations	\$ 16,543	\$ 16,196
Ambulatory Care	6,319	6,195
Conifer	961	974
Total	\$ 23,823	\$ 23,365

	Three Months Ended March 31,	
	2020	2019
Capital expenditures:		
Hospital Operations	\$ 167	\$ 170
Ambulatory Care	11	20
Conifer	4	2
Total	\$ 182	\$ 192

Net operating revenues:		
Hospital Operations total prior to inter-segment eliminations	\$ 3,834	\$ 3,862
Ambulatory Care	490	480
Conifer		
Tenet	136	146
Other clients	196	203
Total Conifer revenues	332	349
Inter-segment eliminations	(136)	(146)
Total	\$ 4,520	\$ 4,545

Equity in earnings of unconsolidated affiliates:		
Hospital Operations	\$ 2	\$ 3
Ambulatory Care	26	31
Total	\$ 28	\$ 34

Adjusted EBITDA:		
Hospital Operations	\$ 342	\$ 347
Ambulatory Care	156	177
Conifer	87	99
Total	\$ 585	\$ 623

Depreciation and amortization:		
Hospital Operations	\$ 175	\$ 179
Ambulatory Care	19	18
Conifer	9	11
Total	\$ 203	\$ 208

	Three Months Ended March 31,	
	2020	2019
Adjusted EBITDA	\$ 585	\$ 623
Loss from divested and closed businesses (i.e., the Company's health plan businesses)	—	(1)
Depreciation and amortization	(203)	(208)
Impairment and restructuring charges, and acquisition-related costs	(55)	(19)
Litigation and investigation costs	(2)	(13)
Interest expense	(243)	(251)
Loss from early extinguishment of debt	—	(47)
Other non-operating expense, net	1	1
Net gains (losses) on sales, consolidation and deconsolidation of facilities	2	(1)
Income from continuing operations, before income taxes	\$ 85	\$ 84

NOTE 19. SUBSEQUENT EVENTS***Impact of the COVID-19 Pandemic***

In March 2020, the global COVID-19 pandemic began to significantly affect our patients, communities, employees and business operations. As the COVID-19 crisis is still rapidly evolving, much of its impact remains unknown and difficult to predict. The spread of COVID-19 and the ensuing response of federal, state and local authorities beginning in March 2020 resulted in a material reduction in our patient volumes and operating revenues that is ongoing. We have cancelled a substantial number of elective procedures at our hospitals and closed or reduced operating hours at our ambulatory surgery centers and other outpatient centers that specialize in elective procedures. Restrictive measures, such as travel bans, social distancing, quarantines and shelter-in-place orders, have also reduced the volume of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits. Broad economic factors resulting from the COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, are impacting our service mix, revenue mix and patient volumes. Moreover, we are experiencing supply chain disruptions, including shortages, delays and significant price increases in medical supplies, particularly personal protective equipment. The length and extent of the disruption to our business as a result of the COVID-19 pandemic is currently unknown. While demand for our services is expected to rebound in the future, we have taken, and continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues from the COVID-19 pandemic, including the sale of senior secured first lien notes and the amendment of our revolving credit facility, both as described below. We also reduced our planned capital expenditures for 2020 by approximately 40%. Furthermore, we have furloughed some employees, and we have deferred certain operating expenses that are not expected to impact our response to COVID-19. We are also reducing variable costs across the enterprise as a result of softening patient volumes. We believe these actions, together with government relief packages, to the extent available to us, will help us to continue operating during these uncertain times.

The Coronavirus Aid, Relief, and Economic Security Act, which was signed into law on March 27, 2020, revised the Medicare accelerated payment program, among other things. Our hospitals, ambulatory surgery centers, physician practices and other outpatient facilities received approximately \$1.500 billion of accelerated payments under this program in April 2020.

Sale of Senior Secured First Lien Notes

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

Amended Credit Facility

As discussed in Note 6, on April 24, 2020, we entered into an amended and restated credit agreement that, among other things, (i) increased the aggregate revolving credit commitments to \$1.9 billion subject to borrowing availability, and (ii) increased the advance rate and raised limits on certain eligible accounts receivable in the calculation of the borrowing base, in each case, for an incremental period of 364 days.

ITEM 2. 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. As described in Note 1 to the accompanying Condensed Consolidated Financial Statements, our results for prior periods have been recast to reflect retrospective application of a change in accounting principle. Our Hospital Operations and other ("Hospital Operations") segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. As described in Note 4 to the accompanying Condensed Consolidated Financial Statements, certain of these facilities are classified as held for sale at March 31, 2020. Our Ambulatory Care segment is comprised of the operations of USPI Holding Company, Inc. ("USPI"), in which we own a 95% interest. At March 31, 2020, USPI had interests in 265 ambulatory surgery centers, 39 urgent care centers, 23 imaging centers and 24 surgical hospitals in 27 states. Our Conifer segment provides revenue cycle management and value-based care services to hospitals, healthcare systems, physician practices, employers and other customers, through our Conifer Holdings, Inc. ("Conifer") subsidiary. Nearly all of the services comprising the operations of our Conifer segment are provided directly by Conifer Health Solutions, LLC, in which we own a 76.2% interest, or by one of its direct or indirect wholly owned subsidiaries. MD&A, which should be read in conjunction with the accompanying Condensed Consolidated Financial Statements, includes the following sections:

- Management Overview
- Forward-Looking Statements
- Sources of Revenue for Our Hospital Operations Segment
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- 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 adjusted patient admission and per adjusted patient day amounts). Continuing operations information includes the results of our same 65 hospitals operated throughout the three months ended March 31, 2020 and 2019, and three Chicago-area hospitals, which we divested effective January 28, 2019. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Impact of the COVID-19 Pandemic—The 2019 novel coronavirus ("COVID-19") pandemic is significantly affecting our patients, communities, employees and business operations. Our operating performance in the three months ended March 31, 2020 was ahead of expectations through February. However, the spread of COVID-19 and the ensuing response of federal, state and local authorities beginning in March 2020 resulted in a material reduction in our patient volumes and operating revenues that is ongoing. We have cancelled a substantial number of elective procedures at our hospitals and closed or reduced operating hours at our ambulatory surgery centers and other outpatient centers that specialize in elective procedures. Restrictive measures, such as travel bans, social distancing, quarantines and shelter-in-place orders, have also reduced the volume of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits. Broad economic factors resulting from the COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, are impacting our service mix, revenue mix and patient volumes. Moreover, we are experiencing supply chain disruptions, including shortages, delays and significant price increases in medical supplies, particularly personal protective equipment. As described below under "Sources of Revenue for Our Hospital Operations Segment," we expect the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which was signed into law on March 27, 2020, as well as other legislative actions, to mitigate some of the economic disruption caused by the COVID-19 pandemic on our business in the months ahead. Throughout MD&A, we have provided additional information on the impact of the COVID-19 pandemic on our results of operations and the steps we have taken, and are continuing to take, in response. To help our employees impacted by the COVID-19 pandemic, our Executive Chairman and Chief Executive Officer will be donating 50%

of his salary for six months (100% for three months) to The Tenet Care Fund, which we established in 2010 as a 501(c)(3) organization to provide assistance to employees who have experienced hardship. Also, our other executive leadership team members will be donating 20% of their salaries for three months, along with many other leaders across the Company who will be donating 10% of their salaries for three months. For information about risks and uncertainties around COVID-19 that could affect our results of operations, financial condition and cash flows, see the Risk Factors section in Part II of this report.

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

TRENDS AND STRATEGIES

As described above and throughout MD&A, we are currently experiencing a disruption in our business due to the COVID-19 pandemic. The length and extent of this disruption is currently unknown. While demand for our services is expected to rebound in the future, we have taken, and continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues from the COVID-19 pandemic, including the sale of senior secured first lien notes and the amendment of our revolving credit facility, both as described below. We also reduced our planned capital expenditures for 2020 by approximately 40%. Furthermore, we have furloughed some employees, and we have deferred certain operating expenses that are not expected to impact our response to COVID-19. We are also reducing variable costs across the enterprise as a result of softening patient volumes. We believe these actions, together with government relief packages, to the extent available to us, will help us to continue operating during these uncertain times. For further information on our liquidity, see “Liquidity and Capital Resources” below.

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

Driving Growth in Our Hospital Systems—We are committed to better positioning our hospital systems and competing more effectively in the ever-evolving healthcare environment by focusing on driving performance through operational effectiveness, increasing capital efficiency and margins, investing in our physician enterprise, particularly our specialist network, enhancing patient and physician satisfaction, growing our higher-demand and higher-acuity clinical service lines (including outpatient lines), expanding patient and physician access, and optimizing our portfolio of assets. Over the past several years, we have undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions (including streamlining corporate overhead and centralized support functions), the renegotiation of contracts with suppliers and vendors, and the consolidation of office locations. Moreover, we established offshore support operations in the Philippines. In conjunction with these initiatives, we incurred restructuring charges related to employee severance payments of \$10 million in the three months ended March 31, 2020, and we expect to incur additional such restructuring charges throughout 2020. We expect to continue in 2020 to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing certain functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

We also continue to exit service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. In December 2019, we entered into a definitive agreement to divest our two hospitals and other operations in the Memphis, Tennessee area. We intend to continue to further refine our portfolio of hospitals and other healthcare facilities when we believe such refinements will help us improve profitability, allocate capital more effectively in areas where we have a stronger presence, deploy proceeds on higher-return investments across our business, enhance cash flow generation, reduce our debt and lower our ratio of debt-to-Adjusted EBITDA.

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

Expansion of Our Ambulatory Care Segment—We expect to continue to focus on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We believe USPI's surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability, flexibility and convenience. Moreover, due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable at a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to increase following the containment of the COVID-19 pandemic. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

Driving Conifer's Growth While Pursuing a Tax-Free Spin-Off—We previously announced a number of actions to support our goals of improving financial performance and enhancing shareholder value, including the exploration of strategic alternatives for Conifer. In July 2019, we announced our intention to pursue a tax-free spin-off of Conifer as a separate, independent, publicly traded company. Completion of the proposed spin-off is subject to a number of conditions, including, among others, assurance that the separation will be tax-free for U.S. federal income tax purposes, execution of a restructured services agreement between Conifer and Tenet, finalization of Conifer's capital structure, the effectiveness of appropriate filings with the Securities and Exchange Commission, and final approval from our board of directors. We are targeting to complete the separation by the end of the second quarter of 2021; however, there can be no assurance regarding the timeframe for completing the spin-off, the allocation of assets and liabilities between Tenet and Conifer, the other conditions of the spin-off will be met, or the spin-off will be completed at all.

Conifer serves approximately 660 Tenet and non-Tenet hospital and other clients nationwide. In addition to providing revenue cycle management services to healthcare systems and physicians, Conifer provides support to both providers and self-insured employers seeking assistance with clinical integration, financial risk management and population health management. Conifer remains focused on driving growth by continuing to market and expand its revenue cycle management and value-based care solutions businesses. We believe that our success in growing Conifer and increasing its profitability depends in part on our success in executing the following strategies: (1) attracting hospitals and other healthcare providers that currently handle their revenue cycle management processes internally as new clients; (2) generating new client relationships through opportunities from USPI and Tenet's acute care hospital acquisition and divestiture activities; (3) expanding revenue cycle management and value-based care service offerings through organic development and small acquisitions; and (4) leveraging data from tens of millions of patient interactions for continued enhancement of the value-based care environment to drive competitive differentiation.

Improving Profitability—Following a return to normal operations post COVID-19, we will continue to focus on growing patient volumes and effective cost management as a means to improve profitability. We believe our inpatient admissions have been constrained in recent years (prior to the COVID-19 pandemic) by increased competition, utilization pressure by managed care organizations, new delivery models that are designed to lower the utilization of acute care hospital services, the effects of higher patient co-pays, co-insurance amounts and deductibles, changing consumer behavior, and adverse economic conditions and demographic trends in certain of our markets. However, we also believe that emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our ambulatory care business, cultivation of our culture of service, participation in Medicare Advantage health plans that have been experiencing higher growth rates than traditional Medicare plans, and contracting strategies that create shared value with payers should help us grow our patient volumes over time. In 2020, we will continue to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing certain functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

Reducing Our Leverage Over Time—All of our outstanding long-term debt has a fixed rate of interest, except for outstanding borrowings under our revolving credit facility, and the maturity dates of our notes are staggered from 2022 through 2031. We believe that our capital structure minimizes the near-term impact of increased interest rates, and the staggered maturities of our debt allow us to refinance our debt over time. Although we recently issued \$700 million aggregate principal

amount of senior secured first lien notes to manage our liquidity during the COVID-19 pandemic, it is nonetheless our long-term objective to reduce our debt and lower our ratio of debt-to-Adjusted EBITDA, primarily through more efficient capital allocation and Adjusted EBITDA growth, which should lower our refinancing risk.

Our ability to execute on our strategies and respond to the aforementioned trends is subject to the length of time of the impact from the COVID-19 pandemic, as well as a number of other risks and uncertainties – all of which may cause actual results to be materially different from expectations. For information about risks and uncertainties that could affect our results of operations, see the Risk Factors section in Part II of this report and the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report on Form 10-K for the year ended December 31, 2019 (“Annual Report”).

RESULTS OF OPERATIONS—OVERVIEW

We have provided below certain selected operating statistics for the three months ended March 31, 2020 and 2019 on a continuing operations basis, which includes the results of our same 65 hospitals operated throughout the three months ended March 31, 2020 and 2019, and three Chicago-area hospitals, which we divested effective January 28, 2019. The following tables also show information about facilities in our Ambulatory Care segment that we control and, therefore, consolidate. We believe this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses. We present certain metrics on a per adjusted patient admission basis to show trends other than volume.

Selected Operating Statistics	Continuing Operations Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Hospital Operations – hospitals and related outpatient facilities			
Number of hospitals (at end of period)	65	65	— ⁽¹⁾
Total admissions	165,735	174,726	(5.1)%
Adjusted patient admissions ⁽²⁾	290,912	308,133	(5.6)%
Paying admissions (excludes charity and uninsured)	155,820	164,793	(5.4)%
Charity and uninsured admissions	9,915	9,933	(0.2)%
Emergency department visits	641,282	657,449	(2.5)%
Total surgeries	95,352	103,013	(7.4)%
Patient days — total	810,479	822,079	(1.4)%
Adjusted patient days ⁽²⁾	1,385,763	1,420,170	(2.4)%
Average length of stay (days)	4.89	4.70	4.0 %
Average licensed beds	17,218	17,455	(1.4)%
Utilization of licensed beds ⁽³⁾	51.7%	52.3%	(0.6)% ⁽¹⁾
Total visits	1,616,527	1,714,392	(5.7)%
Paying visits (excludes charity and uninsured)	1,499,538	1,603,712	(6.5)%
Charity and uninsured visits	116,989	110,680	5.7 %
Ambulatory Care			
Total consolidated facilities (at end of period)	244	226	18 ⁽¹⁾
Total cases	501,226	496,988	0.9 %

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

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

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

Total admissions decreased by 8,991, or 5.1%, in the three months ended March 31, 2020 compared to the three months ended March 31, 2019, and total surgeries decreased by 7,661, or 7.4%, in the 2020 period compared to the 2019 period. Our emergency department visits decreased 2.5% in the three months ended March 31, 2020 compared to the same period in the prior year. Our volumes from continuing operations in the three months ended March 31, 2020 compared to the three months ended March 31, 2019 were negatively affected by the cancellation of a substantial number of elective procedures at our hospitals due to the COVID-19 pandemic, as well as the divestiture of three Chicago-area hospitals and affiliated operations effective January 28, 2019. Our Ambulatory Care total cases increased 0.9% in the three months ended March 31, 2020 compared to the 2019 period. Beginning in late March 2020, we closed or reduced operating hours at our ambulatory surgery centers and other outpatient centers that specialize in elective procedures due to the COVID-19 pandemic.

Revenues	Continuing Operations Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Net operating revenues			
Hospital Operations prior to inter-segment eliminations	\$ 3,834	\$ 3,862	(0.7)%
Ambulatory Care	490	480	2.1 %
Conifer	332	349	(4.9)%
Inter-segment eliminations	(136)	(146)	(6.8)%
Total	\$ 4,520	\$ 4,545	(0.6)%

Net operating revenues decreased by \$25 million, or 0.6%, in the three months ended March 31, 2020 compared to the same period in 2019, primarily due to decreased volumes as a result of the COVID-19 pandemic, partially offset by increased acuity and improved terms of our managed care contracts.

Our accounts receivable days outstanding (“AR Days”) from continuing operations were 60.7 days at March 31, 2020 and 58.4 days at December 31, 2019, compared to our target of less than 55 days. This calculation includes our Hospital Operations contract assets, as well as the accounts receivable of our Memphis-area facilities that have been classified in assets held for sale on our Consolidated Balance Sheet at March 31, 2020, and excludes (i) three Chicago-area hospitals, which we divested effective January 28, 2019, and (ii) our California provider fee revenues.

Selected Operating Expenses	Continuing Operations Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Hospital Operations			
Salaries, wages and benefits	\$ 1,846	\$ 1,813	1.8 %
Supplies	650	641	1.4 %
Other operating expenses	862	919	(6.2)%
Total	\$ 3,358	\$ 3,373	(0.4)%
Ambulatory Care			
Salaries, wages and benefits	\$ 162	\$ 153	5.9 %
Supplies	112	99	13.1 %
Other operating expenses	86	82	4.9 %
Total	\$ 360	\$ 334	7.8 %
Conifer			
Salaries, wages and benefits	\$ 179	\$ 185	(3.2)%
Supplies	1	1	— %
Other operating expenses	65	64	1.6 %
Total	\$ 245	\$ 250	(2.0)%
Total			
Salaries, wages and benefits	\$ 2,187	\$ 2,151	1.7 %
Supplies	763	741	3.0 %
Other operating expenses	1,013	1,065	(4.9)%
Total	\$ 3,963	\$ 3,957	0.2 %
Rent/lease expense⁽¹⁾			
Hospital Operations	\$ 65	\$ 59	10.2 %
Ambulatory Care	23	20	15.0 %
Conifer	3	3	— %
Total	\$ 91	\$ 82	11.0 %

⁽¹⁾ Included in other operating expenses.

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Hospital Operations			
Salaries, wages and benefits per adjusted patient admission ⁽¹⁾	\$ 6,347	\$ 5,881	7.9 %
Supplies per adjusted patient admission ⁽¹⁾	2,236	2,078	7.6 %
Other operating expenses per adjusted patient admission ⁽¹⁾	2,961	2,986	(0.8)%
Total per adjusted patient admission	\$ 11,544	\$ 10,945	5.5 %

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

Salaries, wages and benefits per adjusted patient admission increased 7.9% in the three months ended March 31, 2020 compared to the same period in 2019. This change was primarily due to reduced patient volumes and the related increase in our patient length-of-stay due to the COVID-19 pandemic, as well as annual merit increases for certain of our employees, a greater number of employed physicians and higher health benefits costs, partially offset by decreased incentive compensation expense in the three months ended March 31, 2020 compared to the three months ended March 31, 2019.

Supplies expense per adjusted patient admission increased 7.6% in the three months ended March 31, 2020 compared to the three months ended March 31, 2019. This change was primarily due to increased acuity and the increased cost of supplies due to the COVID-19 pandemic.

Other operating expenses per adjusted patient admission decreased by 0.8% in the three months ended March 31, 2020 compared to the prior-year period. This decrease was primarily due to reduced malpractice expense, which was \$40 million lower in the 2020 period compared to the 2019 period, decreased software costs, decreased consulting and legal costs, and decreased costs associated with funding indigent care services at our hospitals, which costs were substantially offset by reduced net patient revenues, partially offset by higher medical fees.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were \$613 million at March 31, 2020 compared to \$262 million at December 31, 2019.

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

- Net cash provided by operating activities before interest, taxes, discontinued operations and restructuring charges, acquisition-related costs, and litigation costs and settlements of \$372 million;
- Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements of \$68 million;
- Capital expenditures of \$182 million;
- Interest payments of \$172 million;
- Purchases of businesses or joint venture interests of \$55 million;
- \$500 million of net cash borrowings under our credit facility; and
- \$76 million of distributions paid to noncontrolling interests.

Net cash provided by operating activities was \$129 million in the three months ended March 31, 2020 compared to \$10 million in the three months ended March 31, 2019. Key factors contributing to the change between the 2020 and 2019 periods include the following:

- \$74 million less cash used in the 2020 period for the annual 401(k) match funding;

- An increase of \$36 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- The timing of other working capital items.

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 Securities Exchange Act of 1934, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, target, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements, including (but not limited to) disclosure regarding (i) the impact of the COVID-19 pandemic, (ii) our future earnings, financial position, operational and strategic initiatives, and (iii) developments in the healthcare industry. Forward-looking statements represent management’s expectations, based on currently available information, as to the outcome and timing of future events, but, by their nature, address matters that are indeterminate. They involve known and unknown risks, uncertainties and other factors, many of which we are unable to predict or control, that may cause our actual results, performance or achievements to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the risks described in the Risk Factors section in Part II of this report and the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

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

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

SOURCES OF REVENUE FOR OUR HOSPITAL OPERATIONS SEGMENT

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

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

Net Patient Service Revenues Less Implicit Price Concessions from:	Three Months Ended March 31,		
	2020	2019	Increase (Decrease) ⁽¹⁾
Medicare	19.9%	21.2%	(1.3)%
Medicaid	7.9%	8.8%	(0.9)%
Managed care ⁽²⁾	65.6%	65.7%	(0.1)%
Uninsured	1.1%	—%	1.1 %
Indemnity and other	5.5%	4.3%	1.2 %

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

⁽²⁾ Includes Medicare and Medicaid managed care programs.

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

Admissions from:	Three Months Ended March 31,		
	2020	2019	Increase (Decrease) ⁽¹⁾
Medicare	24.5%	26.1%	(1.6)%
Medicaid	6.0%	6.0%	— %
Managed care ⁽²⁾	60.7%	59.7%	1.0 %
Charity and uninsured	6.0%	5.7%	0.3 %
Indemnity and other	2.8%	2.5%	0.3 %

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

⁽²⁾ Includes Medicare and Medicaid managed care programs.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services (“CMS”), an agency of the U.S. Department of Health and Human Services (“HHS”), is the single largest payer of healthcare services in the United States. Approximately 60 million individuals rely on healthcare benefits through Medicare, and approximately 72 million individuals are enrolled in Medicaid and the Children’s Health Insurance Program (“CHIP”). These three programs are authorized by federal law and administered by CMS. Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, as well as some younger people with certain disabilities and conditions, and is provided without regard to income or assets. Medicaid is co-administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation’s main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also co-administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage. Unlike Medicaid, the CHIP is limited in duration and requires the enactment of reauthorizing legislation. During the three months ended March 31, 2018, separate pieces of legislation were enacted extending CHIP funding for a total of 10 years from federal fiscal year (“FFY”) 2018 (which began on October 1, 2017) through FFY 2027.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes “Part A” and “Part B”), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called “Part C” or “MA Plans”), includes health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient service revenues from continuing operations of the hospitals and related outpatient facilities in our Hospital Operations segment for services provided to patients enrolled in the Original Medicare Plan for the three months ended March 31, 2020 and 2019 are set forth in the following table:

Revenue Descriptions	Three Months Ended March 31,	
	2020	2019
Medicare severity-adjusted diagnosis-related group — operating	\$ 390	\$ 404
Medicare severity-adjusted diagnosis-related group — capital	35	36
Outliers	19	23
Outpatient	174	190
Disproportionate share	54	59
Other ⁽¹⁾	33	46
Total Medicare net patient service revenues	\$ 705	\$ 758

⁽¹⁾ The other revenue category includes Medicare Direct Graduate Medical Education and Indirect Medical Education (“IME”) revenues, IME revenues earned by our children’s hospital under the Children’s Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS, inpatient psychiatric units, inpatient rehabilitation units, other revenue adjustments, and adjustments to the estimates for current and prior-year cost reports and related valuation allowances.

A general description of the types of payments we receive for services provided to patients enrolled in the Original Medicare Plan is provided in our Annual Report. 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.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded Medicaid managed care programs, constituted approximately 18.1% and 19.0% of total net patient service revenues less implicit price concessions of our acute care hospitals and related outpatient facilities for the three months ended March 31, 2020 and 2019, respectively. We also receive disproportionate share hospital (“DSH”) and other supplemental revenues under various state Medicaid programs. For the three months ended March 31, 2020 and 2019, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately \$182 million and \$199 million, respectively. The 2020 period included \$58 million related to the California provider fee program, \$58 million related to the Michigan provider fee program, \$46 million related to Medicaid DSH programs in multiple states, \$12 million related to the Texas 1115 waiver program, and \$8 million from a number of other state and local programs.

Even prior to the COVID-19 pandemic, several states in which we operate faced budgetary challenges that resulted in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state’s budget, states can be expected to adopt or consider adopting future legislation designed to reduce or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted supplemental payment programs authorized under the Social Security Act. Continuing pressure on state budgets and other factors could adversely affect the Medicaid supplemental payments our hospitals receive.

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

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

Hospital Location	Three Months Ended March 31,	
	2020	2019
Alabama	\$ 27	\$ 24
Arizona	37	34
California	203	226
Florida	50	52
Illinois	—	5
Massachusetts	25	22
Michigan	178	187
South Carolina	17	14
Tennessee	9	8
Texas	95	108
	\$ 641	\$ 680

Medicaid and Managed Medicaid revenues comprised 44% and 56%, respectively, of our Medicaid-related net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations segment for the three months ended March 31, 2020.

Regulatory and Legislative Changes

Material updates to the information set forth in our Annual Report about the Medicare and Medicaid payment systems, as well as other government programs impacting our business, are provided below.

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

The CARES Act, which was signed into law on March 27, 2020, aims to mitigate the economic disruption caused by the COVID-19 pandemic and authorizes up to \$2 trillion in government spending to accomplish that goal. Among the vast array of spending provisions is an additional \$100 billion for the Public Health and Social Services Emergency Fund (“PHSS Emergency Fund”), which is designed to provide an influx of money to hospitals and other healthcare entities responding to the pandemic. We have provided below a brief overview of certain provisions of the CARES Act and related legislation that have impacted and we expect will continue to impact our business in the months ahead. Please note that this summary is not exhaustive, and additional legislative action and regulatory developments may evolve rapidly. There is no assurance that we will continue to receive or remain eligible for funding or assistance under the CARES Act or similar measures. Statements regarding the projected impact of COVID-19 relief programs on our operations and financial condition are forward-looking and are made as of the date of this filing.

PHSS Emergency Fund Disbursements. Payments from the PHSS Emergency Fund are intended to support healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic and to ensure uninsured Americans can get testing and treatment for COVID-19, with \$50 billion allocated for general distribution to certain eligible healthcare providers. Between April 10 and April 17, 2020, HHS made an initial distribution of payments from the PHSS Emergency Fund to eligible providers totaling \$30 billion. This quick dispersal of funds was intended to provide relief to both providers in areas heavily impacted by the COVID-19 pandemic and those providers who are struggling to remain operational due to cancelled and delayed elective services. All facilities and providers that received Medicare fee-for-service (“FFS”) reimbursements in 2019 were eligible for this initial rapid distribution. Based on our share of total Medicare FFS reimbursements in 2019, we received PHSS Emergency Fund payments of approximately \$225 million in mid-April 2020.

On April 22, 2020, HHS announced the release of the remaining \$70 billion of the \$100 billion PHSS Emergency Fund appropriated in the CARES Act, including, among other allocations: (i) \$20 billion (remaining from the initial \$50 billion allocation described above) for general distribution to eligible healthcare facilities and providers; (ii) \$10 billion for hospitals determined to be in areas particularly impacted by COVID-19; and (iii) an unspecified portion for the treatment of the uninsured and possibly other further releases for Medicaid providers. Payments to eligible providers from the additional \$20 billion of general allocation funds were calculated to rebalance the entire \$50 billion general distribution such that it is based on total 2018 net patient revenue rather than Medicare FFS reimbursements. HHS began disbursing payments on April 24, 2020. Based on our share of 2018 net patient revenue, we estimate we will receive additional payments of approximately \$145 million. As a result, we estimate we will receive total payments of approximately \$370 million from the total \$50 billion general distribution to eligible healthcare providers.

The targeted \$10 billion allocation to hospitals in areas acutely hit by the COVID-19 pandemic will be distributed based on the submission of an application for such funds, which was due on April 25, 2020, and the applicant’s Medicare DSH payments. Completion of an application is not a guarantee of eligibility nor receipt of any amounts from this distribution. Although we applied for a portion of this funding for certain of our hospitals, there is no assurance that we will receive any related payments.

The Health Resources & Services Administration will administer the program intended to reimburse healthcare providers who treat uninsured COVID-19 patients with dates of service or admittance on or after February 4, 2020. Claims may be submitted electronically and, if eligible, will be reimbursed at Medicare rates, subject to available funding and timely filing requirements. Although we have registered for the program and expect to begin submitting claims in May 2020, we can give no assurances that we will receive reimbursement for such claims from the PHSS Emergency Fund.

Payments from the PHSS Emergency Fund are not loans and, therefore, they are not subject to repayment. However, as a condition to receiving PHSS Emergency Fund payments, providers must submit sufficient documentation demonstrating that the funds are being used for healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic. In addition, providers must agree to certain terms and conditions, including, among other things, not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. Furthermore, HHS has indicated that it will be closely monitoring and, along with the Office of Inspector General, auditing providers to ensure that recipients comply with the terms and conditions of relief programs and to prevent fraud and abuse. All providers will be subject to civil and criminal penalties for any deliberate omissions, misrepresentations or falsifications of any information given to HHS. We are in the process of evaluating and accepting the terms and conditions associated with the receipt of PHSS Emergency Fund payments where appropriate and within the required timeframes.

The Paycheck Protection Program and Health Care Enhancement Act (the “Enhancement Act”), a \$484 billion COVID-19 emergency supplemental package, was signed into law on April 24, 2020. Among other things, the Enhancement Act provides an additional \$100 billion for the PHSS Emergency Fund consisting of \$75 billion for eligible healthcare providers to continue to address COVID-19 related expenses and lost revenue and \$25 billion for COVID-19 testing. Because CMS has not yet released any guidance with respect to how these funds will be allocated, it is unclear at this time whether we will be eligible for any additional payments or, if we are, the amount and timing thereof.

Medicare and Medicaid Policy Changes. The CARES Act also seeks to alleviate some of the financial strain on hospitals, physicians, and other healthcare providers through a series of new Medicare policies that temporarily boost Medicare and Medicaid reimbursement and allow for added flexibility.

- Effective May 1, 2020, the annual 2% sequestration revenue reduction in Medicare FFS and Medicare Advantage payments to hospitals, physicians and other providers will be suspended for the rest of calendar year (“CY”) 2020. The projected impact of this change on our operations is an increase of approximately \$67 million of revenues in 2020, which is not subject to repayment. The 2% sequestration revenue reduction is scheduled to resume again in CY 2021. In order to offset the added expense of the 2020 suspension, the CARES Act extends the sequestration revenue reduction by one year through 2030.
- The weighting factor that would otherwise apply to the severity-adjusted diagnosis-related group (“DRG”) to which a COVID-19 patient discharge is assigned under the Medicare inpatient prospective payment systems (“IPPS”) has been increased by 20%. The add-on payment will be available for the duration of the public health emergency as declared by the Secretary of HHS (the “COVID-19 emergency period”).
- The scheduled reduction of \$4 billion in Medicaid DSH payments in FFY 2020, as mandated by the Affordable Care Act, will be suspended until December 1, 2020. The projected impact of this change on our operations is an increase of approximately \$60 million in revenues in 2020, which is not subject to repayment. Also, the DSH revenue reduction for FFY 2021 will be reduced from \$8 billion to \$4 billion. Notwithstanding these adjustments, the ACA-mandated reduction is not expected to be extended past its original termination in FFY 2025.

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

Expansion of Medicare Accelerated Payments Program. In certain circumstances, when a hospital is experiencing financial difficulty due to delays in receiving payment for Medicare services provided, it may be eligible for an accelerated or advance payment pursuant to the Medicare accelerated payment program. In an attempt to disburse payments to hospitals more quickly to mitigate shortfalls due to delays in non-essential procedures, as well as staffing and billing disruptions, the CARES Act revises the Medicare accelerated payment program to:

- Increase the prepayment amount from 70% to 100% (125% for critical access hospitals) of expected Medicare payments;
- Increase the length of time accelerated payments may cover from three to six months;
- Delay the start of recoupment of any overpayments from 90 to 120 days (repayment of advance payments will be effectuated through an automatic 100% offset against future claims payments); and
- Extend the due date for any outstanding balances from 90 days to one year for hospitals; all other providers will have 210 days to repay the advance payment.

Medicare started accepting and processing accelerated payment requests immediately, and CMS anticipates that payments will be issued within seven days of the approval of the provider’s request. The CARES Act also expands the Medicare accelerated payment program for the duration of the COVID-19 emergency period to children’s hospitals, cancer hospitals and critical access hospitals. Our hospitals, ambulatory surgery centers, physician practices and other outpatient facilities received approximately \$1.500 billion of accelerated payments under this program in April 2020.

Enhanced Medicaid Matching Funding. The CARES Act amends a section of the Families First Coronavirus Response Act of 2020 to increase federal matching funding of traditional state Medicaid programs by 6.2 percentage points, which is anticipated to result in additional Medicaid payment rates to providers. The amount and timing of such payments are not currently known or estimable. This enhanced Medicaid matching funding will be available through the end of the calendar quarter following termination of the COVID-19 emergency period.

Stabilization Loans. The CARES Act allocates \$500 billion to the U.S. Treasury's Exchange Stabilization Fund (the "Stabilization Fund") to provide loans, loan guarantees and other investments to businesses, states and municipalities needing economic relief due to the COVID-19 pandemic. The Stabilization Fund specifically allocated \$46 billion to passenger air carriers, cargo air carriers and businesses important to maintaining national security, with the remaining \$454 billion available to fund loans to businesses, states and municipalities needing economic relief.

Tax Changes. Beginning March 27, 2020, all employers may elect to defer payment of the 6.2% employer Social Security tax through December 31, 2020. Deferred tax amounts are required to be paid in equal amounts over two years, with payments due in December 2021 and December 2022. We expect that we will defer approximately \$250 million of taxes in 2020 pursuant to this CARES Act provision.

In addition, the CARES Act increases the limitation from 30% of adjusted taxable income to 50% of adjusted taxable income for the 2019 and 2020 tax years, allowing businesses to take a larger interest expense deduction. This change is expected to increase our federal tax net operating loss ("NOL") carryforwards into future years, as further described in Note 14 to the accompanying Condensed Consolidated Financial Statements.

PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service healthcare delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate healthcare can be efficiently delivered in the most cost-effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted healthcare providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted healthcare providers. PPO members who use contracted healthcare providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible healthcare plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient service revenues, including Medicare and Medicaid managed care programs, from our hospitals and related outpatient facilities during the three months ended March 31, 2020 and 2019 was \$2.321 billion and \$2.354 billion, respectively. Our top ten managed care payers generated 61% of our managed care net patient service revenues for the three months ended March 31, 2020. National payers generated 44% of our managed care net patient service revenues for the three months ended March 31, 2020. The remainder comes from regional or local payers. At March 31, 2020 and December 31, 2019, 64% and 65%, respectively, of our net accounts receivable for our Hospital Operations segment were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at March 31, 2020, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately \$12 million. Some of the factors that can contribute to changes in the contractual allowance

estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage and payment levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. We believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for these payers and other factors that affect the estimation process.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefited from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate in recent years, and we believe the moderation could continue in future years. In the three months ended March 31, 2020, our commercial managed care net inpatient revenue per admission from the hospitals and related outpatient facilities in our Hospital Operations segment was approximately 96% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

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

UNINSURED PATIENTS

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

Self-pay accounts receivable, which include amounts due from uninsured patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance, pose significant collectability problems. At both March 31, 2020 and December 31, 2019, approximately 4% of our net accounts receivable for our Hospital Operations segment was self-pay. Further, a significant portion of our implicit price concessions relates to self-pay amounts. We provide revenue cycle management services through Conifer, which is subject to various statutes and regulations regarding consumer protection in areas including finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of our Annual Report.

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

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

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

The following table shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our uninsured and charity patients in the three months ended March 31, 2020 and 2019:

	Three Months Ended March 31,	
	2020	2019
Estimated costs for:		
Uninsured patients	\$ 156	\$ 158
Charity care patients	40	34
Total	\$ 196	\$ 192

RESULTS OF OPERATIONS

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the three months ended March 31, 2020 and 2019. We present metrics as a percentage of net operating revenues because a significant portion of our costs are variable.

	Three Months Ended March 31,	
	2020	2019
Net operating revenues:		
Hospital Operations	\$ 3,834	\$ 3,862
Ambulatory Care	490	480
Conifer	332	349
Inter-segment eliminations	(136)	(146)
Net operating revenues	4,520	4,545
Equity in earnings of unconsolidated affiliates	28	34
Operating expenses:		
Salaries, wages and benefits	2,187	2,151
Supplies	763	741
Other operating expenses, net	1,013	1,065
Depreciation and amortization	203	208
Impairment and restructuring charges, and acquisition-related costs	55	19
Litigation and investigation costs	2	13
Net losses (gains) on sales, consolidation and deconsolidation of facilities	(2)	1
Operating income	\$ 327	\$ 381

	Three Months Ended March 31,	
	2020	2019
Net operating revenues	100.0 %	100.0%
Equity in earnings of unconsolidated affiliates	0.6 %	0.7%
Operating expenses:		
Salaries, wages and benefits	48.4 %	47.3%
Supplies	16.9 %	16.3%
Other operating expenses, net	22.4 %	23.4%
Depreciation and amortization	4.5 %	4.6%
Impairment and restructuring charges, and acquisition-related costs	1.2 %	0.4%
Litigation and investigation costs	— %	0.3%
Net gains on sales, consolidation and deconsolidation of facilities	— %	—%
Operating income	7.2 %	8.4%

Total net operating revenues decreased by \$25 million, or 0.6%, for the three months ended March 31, 2020 compared to the three months ended March 31, 2019. Hospital Operations net operating revenues net of inter-segment eliminations decreased by \$18 million, or 0.5%, for the three months ended March 31, 2020 compared to the same period in 2019, primarily due to the negative impact of the cancellation of a substantial number of elective procedures at our hospitals due to the COVID-19 pandemic. Ambulatory Care net operating revenues increased by \$10 million, or 2.1%, for the three months ended March 31, 2020 compared to the prior-year period. This growth was driven by an increase in same-facility net operating revenues of \$9 million and an increase from acquisitions of \$6 million, partially offset by a decrease of \$5 million due to the deconsolidation of a facility. Conifer net operating revenues decreased by \$17 million, or 4.9%, for the three months ended March 31, 2020 compared to the three months ended March 31, 2019. Conifer revenues from third-party customers, which are not eliminated in consolidation, decreased \$7 million, or 3.4%, for the three months ended March 31, 2020 compared to the same period in 2019. Conifer revenues from third-party customers were negatively impacted by the wind-down and termination of contracts for facilities we previously owned then divested, as well as other client terminations at the end of their contract terms.

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

Selected Operating Expenses	Three Months Ended March 31,		Increase (Decrease)
	2020	2019	
Hospital Operations — Same-Hospital			
Salaries, wages and benefits	\$ 1,846	\$ 1,796	2.8 %
Supplies	651	637	2.2 %
Other operating expenses	870	909	(4.3)%
Total	\$ 3,367	\$ 3,342	0.7 %
Ambulatory Care			
Salaries, wages and benefits	\$ 162	\$ 153	5.9 %
Supplies	112	99	13.1 %
Other operating expenses	86	82	4.9 %
Total	\$ 360	\$ 334	7.8 %
Conifer			
Salaries, wages and benefits	\$ 179	\$ 185	(3.2)%
Supplies	1	1	— %
Other operating expenses	65	64	1.6 %
Total	\$ 245	\$ 250	(2.0)%
Total			
Salaries, wages and benefits	\$ 2,187	\$ 2,134	2.5 %
Supplies	764	737	3.7 %
Other operating expenses	1,021	1,055	(3.2)%
Total	\$ 3,972	\$ 3,926	1.2 %
Rent/lease expense⁽¹⁾			
Hospital Operations	\$ 65	\$ 59	10.2 %
Ambulatory Care	23	20	15.0 %
Conifer	3	3	— %
Total	\$ 91	\$ 82	11.0 %

⁽¹⁾ Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported in three segments:

- Hospital Operations, which is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, micro-hospitals and physician practices. As described in Note 4 to the accompanying

Condensed Consolidated Financial Statements, certain of these facilities are classified as held for sale at March 31, 2020.

- Ambulatory Care, which is comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals.
- Conifer, which provides revenue cycle management and value-based care services to hospitals, healthcare systems, physician practices, employers and other customers.

Hospital Operations Segment

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

	Same-Hospital Continuing Operations		
	Three Months Ended March 31,		
Admissions, Patient Days and Surgeries	2020	2019	Increase (Decrease)
Number of hospitals (at end of period)	65	65	— (1)
Total admissions	165,735	173,470	(4.5)%
Adjusted patient admissions ⁽²⁾	290,912	305,871	(4.9)%
Paying admissions (excludes charity and uninsured)	155,820	163,632	(4.8)%
Charity and uninsured admissions	9,915	9,838	0.8 %
Admissions through emergency department	122,291	125,228	(2.3)%
Paying admissions as a percentage of total admissions	94.0%	94.3%	(0.3)% (1)
Charity and uninsured admissions as a percentage of total admissions	6.0%	5.7%	0.3 % (1)
Emergency department admissions as a percentage of total admissions	73.8%	72.2%	1.6 % (1)
Surgeries — inpatient	41,962	44,553	(5.8)%
Surgeries — outpatient	53,390	57,896	(7.8)%
Total surgeries	95,352	102,449	(6.9)%
Patient days — total	810,479	815,329	(0.6)%
Adjusted patient days ⁽²⁾	1,385,763	1,408,053	(1.6)%
Average length of stay (days)	4.89	4.70	4.0 %
Licensed beds (at end of period)	17,219	17,221	— %
Average licensed beds	17,218	17,221	— %
Utilization of licensed beds ⁽³⁾	51.7%	52.6%	(0.9)% (1)

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

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

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

	Same-Hospital Continuing Operations		
	Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Outpatient Visits			
Total visits	1,616,527	1,686,864	(4.2)%
Paying visits (excludes charity and uninsured)	1,499,540	1,577,635	(5.0)%
Charity and uninsured visits	116,987	109,229	7.1 %
Emergency department visits	641,282	651,852	(1.6)%
Surgery visits	53,390	57,896	(7.8)%
Paying visits as a percentage of total visits	92.8%	93.5%	(0.7)% ⁽¹⁾
Charity and uninsured visits as a percentage of total visits	7.2%	6.5%	0.7 % ⁽¹⁾

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

	Same-Hospital Continuing Operations		
	Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Revenues			
Total segment net operating revenues ⁽¹⁾	\$ 3,700	\$ 3,690	0.3 %
Selected revenue data – hospitals and related outpatient facilities			
Net patient service revenues ⁽¹⁾⁽²⁾	\$ 3,542	\$ 3,557	(0.4)%
Net patient service revenue per adjusted patient admission ⁽¹⁾⁽²⁾	\$ 12,176	\$ 11,629	4.7 %
Net patient service revenue per adjusted patient day ⁽¹⁾⁽²⁾	\$ 2,556	\$ 2,526	1.2 %

⁽¹⁾ Revenues are net of implicit price concessions.

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

	Same-Hospital Continuing Operations		
	Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Total Segment Selected Operating Expenses			
Salaries, wages and benefits as a percentage of net operating revenues	49.9%	48.7%	1.2 % ⁽¹⁾
Supplies as a percentage of net operating revenues	17.6%	17.3%	0.3 % ⁽¹⁾
Other operating expenses as a percentage of net operating revenues	23.5%	24.6%	(1.1)% ⁽¹⁾

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

Revenues

Same-hospital net operating revenues increased \$10 million, or 0.3%, during the three months ended March 31, 2020 compared to the three months ended March 31, 2019, primarily due to increased acuity and improved terms of our managed care contracts, partially offset by the negative impact of the cancellation of a substantial number of elective procedures at our hospitals due to the COVID-19 pandemic. Same-hospital admissions decreased 4.5% in the three months ended March 31, 2020 compared to the same period in 2019. Same-hospital outpatient visits decreased 4.2% in the three months ended March 31, 2020 compared to the prior-year period.

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

	March 31, 2020	December 31, 2019
Medicare	\$ 180	\$ 189
Medicaid	64	69
Net cost report settlements receivable and valuation allowances	37	12
Managed care	1,624	1,618
Self-pay uninsured	19	25
Self-pay balance after insurance	78	76
Estimated future recoveries	163	162
Other payers	361	337
Total Hospital Operations	2,526	2,488
Ambulatory Care	195	253
Total discontinued operations	1	2
	\$ 2,722	\$ 2,743

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

Collection of accounts receivable has been a key area of focus, particularly over the past several years. At March 31, 2020, our Hospital Operations segment collection rate on self-pay accounts was approximately 22.5%. Our self-pay collection rate includes payments made by patients, including co-pays, co-insurance amounts and deductibles paid by patients with insurance. Based on our accounts receivable from uninsured patients and co-pays, co-insurance amounts and deductibles owed to us by patients with insurance at March 31, 2020, a 10% decrease or increase in our self-pay collection rate, or approximately 2%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to patient accounts receivable of approximately \$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.

Payment pressure from managed care payers also affects the collectability of our accounts receivable. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated Hospital Operations segment collection rate from managed care payers was approximately 98.1% at March 31, 2020.

We manage our implicit price concessions using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) AR Days and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations segment of \$2.489 billion and \$2.476 billion at March 31, 2020 and December 31, 2019, respectively, excluding cost report settlements receivable and valuation allowances of \$37 million and \$12 million, respectively, at March 31, 2020 and December 31, 2019:

March 31, 2020					
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	89%	36%	53%	21%	48%
61-120 days	7%	26%	17%	15%	16%
121-180 days	2%	13%	10%	10%	9%
Over 180 days	2%	25%	20%	54%	27%
Total	100%	100%	100%	100%	100%

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

Conifer continues to implement revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collections at point-of-service, and financial counseling. These initiatives are intended to reduce denials, improve service levels to patients and increase the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

At March 31, 2020, we had a cumulative total of patient account assignments to Conifer of \$2.987 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to Conifer is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer’s Medicaid Eligibility Program (“MEP”) screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. Based on recent trends, approximately 98% 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 March 31, 2020 and December 31, 2019 by aging category:

	March 31, 2020	December 31, 2019
0-60 days	\$ 68	\$ 89
61-120 days	12	11
121-180 days	4	4
Over 180 days	5	11
Total	\$ 89	\$ 115

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits as a percentage of net operating revenues increased by 120 basis points to 49.9% in the three months ended March 31, 2020 compared to the same period in 2019. Same-hospital net operating revenues increased 0.3% during the three months ended March 31, 2020 compared to the three months ended March 31, 2019, and same-hospital salaries, wages and benefits increased by 2.8% in the three months ended March 31, 2020 compared to the 2019 period. The change in same-hospital salaries, wages and benefits as a percentage of net operating revenues was primarily due to reduced patient volumes caused by the cancellation of a substantial number of elective procedures at our hospitals and the related increase in our patient length-of-stay due to the COVID-19 pandemic, as well as annual merit increases for certain of our employees, a greater number of employed physicians and increased health benefits costs, partially offset by decreased incentive compensation expense. Salaries, wages and benefits expense for the three months ended March 31, 2020 and 2019 included stock-based compensation expense of \$7 million and \$6 million, respectively.

Supplies

Same-hospital supplies expense as a percentage of net operating revenues increased by 30 basis points to 17.6% in the three months ended March 31, 2020 compared to the same period in 2019. This change was primarily due increased acuity and the increased cost of supplies due to the COVID-19 pandemic.

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

Other Operating Expenses, Net

Same-hospital other operating expenses as a percentage of net operating revenues decreased by 110 basis points to 23.5% in the three months ended March 31, 2020 compared to 24.6% in the same period in 2019. Same-hospital other operating expenses decreased by \$39 million, or 4.3%, for the three months ended March 31, 2020 compared to the three months ended March 31, 2019. The changes in other operating expenses included:

- increased medical fees of \$27 million;
- decreased software costs of \$12 million;
- decreased consulting and legal fees of \$11 million;
- decreased malpractice expense of \$39 million; and
- decreased costs of \$13 million associated with funding indigent care services at our hospitals, which costs were substantially offset by reduced net patient revenues.

Ambulatory Care Segment

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

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

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. For many of the facilities our Ambulatory Care segment operates (107 of 351 facilities at March 31, 2020), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method for

an unconsolidated affiliate. USPI controls 244 of the facilities our Ambulatory Care segment operates, and we account for these investments as consolidated subsidiaries. Our net earnings from a facility are the same under either method, but the classification of those earnings differs. For consolidated subsidiaries, our financial statements reflect 100% of the revenues and expenses of the subsidiaries, after the elimination of intercompany amounts. The net profit attributable to owners other than USPI is classified within “net income available to noncontrolling interests.”

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

- *equity in earnings of unconsolidated affiliates*—our share of the net income (loss) of each facility, which is based on the facility’s net income (loss) and the percentage of the facility’s outstanding equity interests owned by USPI; and
- *management and administrative services revenues, which is included in our net operating revenues*—income we earn in exchange for managing the day-to-day operations of each facility, usually quantified as a percentage of each facility’s net revenues less implicit price concessions.

Our Ambulatory Care segment operating income is driven by the performance of all facilities USPI operates and by USPI’s ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 70% of those facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses, which is why we disclose certain statistical and financial data on a pro forma systemwide basis that includes both consolidated and unconsolidated (equity method) facilities.

Results of Operations

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

Ambulatory Care Results of Operations	Three Months Ended March 31,		
	2020	2019	Increase (Decrease)
Net operating revenues	\$ 490	\$ 480	2.1 %
Equity in earnings of unconsolidated affiliates	\$ 26	\$ 31	(16.1)%
Salaries, wages and benefits	\$ 162	\$ 153	5.9 %
Supplies	\$ 112	\$ 99	13.1 %
Other operating expenses, net	\$ 86	\$ 82	4.9 %

Our Ambulatory Care net operating revenues increased by \$10 million, or 2.1%, during the three months ended March 31, 2020 as compared to the three months ended March 31, 2019. The change was driven by an increase in same-facility net operating revenues of \$9 million and an increase from acquisitions of \$6 million, partially offset by a decrease of \$5 million due to the deconsolidation of a facility.

Salaries, wages and benefits expense increased by \$9 million, or 5.9%, during the three months ended March 31, 2020 as compared to the three months ended March 31, 2019. Salaries, wages and benefits expense was impacted by an increase in same-facility salaries, wages and benefits expense of \$8 million and an increase from acquisitions of \$2 million, partially offset by a decrease of \$1 million due to the deconsolidation of a facility.

Supplies expense increased by \$13 million, or 13.1%, during the three months ended March 31, 2020 as compared to the three months ended March 31, 2019. The change was driven by an increase in same-facility supplies expense of \$12 million and an increase from acquisitions of \$2 million, partially offset by a decrease of \$1 million due to the deconsolidation of a facility.

Other operating expenses increased by \$4 million, or 4.9%, during the three months ended March 31, 2020 as compared to the three months ended March 31, 2019. The change was driven by an increase in same-facility other operating expenses of \$3 million and an increase from acquisitions of \$2 million, partially offset by a decrease of \$1 million due to the deconsolidation of a facility.

Facility Growth

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

Ambulatory Care Facility Growth	Three Months Ended March 31, 2020
Net revenues	(1.5)%
Cases	(4.3)%
Net revenue per case	2.9%

Joint Ventures with Healthcare System Partners

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

Ambulatory Care Facilities	Three Months Ended March 31, 2020
Facilities:	
With a healthcare system partner	223
Without a healthcare system partner	128
Total facilities operated	351
Change from December 31, 2019	
Acquisitions	5
De novo	2
Dispositions/Mergers	(2)
Total increase in number of facilities operated	5

During the three months ended March 31, 2020, we acquired controlling interests in one multi-specialty surgery center in each of Colorado, Tennessee and Arizona, and two in Florida. We paid cash totaling approximately \$54 million for these acquisitions. All of these acquired facilities are jointly owned with local physicians, and a healthcare system partner is an owner in all of the facilities except the two facilities in Florida.

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

Conifer Segment

Our Conifer segment generated net operating revenues of \$332 million and \$349 million during the three months ended March 31, 2020 and 2019, respectively, a portion of which was eliminated in consolidation as described in Note 18 to the accompanying Condensed Consolidated Financial Statements. Conifer revenues from third-party customers, which are not eliminated in consolidation, decreased \$7 million, or 3.4%, for the three months ended March 31, 2020 compared to the three months ended March 31, 2019. Conifer revenues from third-party customers were negatively impacted by the wind-down and termination of contracts for facilities we previously owned then divested, as well as other client terminations at the end of their contract terms.

Salaries, wages and benefits expense for Conifer decreased \$6 million, or 3.2%, in the three months ended March 31, 2020 compared to the three months ended March 31, 2019 primarily due to the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives.

Other operating expenses for Conifer increased \$1 million, or 1.6%, in the three months ended March 31, 2020 compared to the three months ended March 31, 2019.

Agreements document the current terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations segment provides to Conifer; however, execution of a restructured services agreement between Conifer and Tenet is a condition to completion of the proposed spin-off. Conifer's contract with Tenet represented 41.0% of the net operating revenues Conifer recognized in the three months ended March 31, 2020.

Consolidated

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the three months ended March 31, 2020, we recorded impairment and restructuring charges and acquisition-related costs of \$55 million, consisting of \$54 million of restructuring charges and \$1 million of acquisition-related costs. Restructuring charges consisted of \$10 million of employee severance costs, \$15 million related to our Global Business Center in the Philippines, \$23 million of charges due to the termination of the USPI management equity plan, \$1 million of contract and lease termination fees, and \$5 million of other restructuring costs. Acquisition-related costs consisted of \$1 million of transaction costs. Our impairment and restructuring charges and acquisition-related costs for the three months ended March 31, 2020 were comprised of \$18 million from our Hospital Operations segment, \$24 million from our Ambulatory Care segment and \$13 million from our Conifer segment.

During the three months ended March 31, 2019, we recorded impairment and restructuring charges and acquisition-related costs of \$19 million, consisting of \$1 million of impairment charges, \$16 million of restructuring charges and \$2 million of acquisition-related costs. Restructuring charges consisted of \$7 million of employee severance costs, \$1 million of contract and lease termination fees, and \$8 million of other restructuring costs. Acquisition-related costs consisted of \$2 million of transaction costs. Our impairment and restructuring charges and acquisition-related costs for the three months ended March 31, 2019 were comprised of \$10 million from our Hospital Operations segment, \$3 million from our Ambulatory Care segment and \$6 million from our Conifer segment.

Litigation and Investigation Costs

Litigation and investigation costs for the three months ended March 31, 2020 and 2019 were \$2 million and \$13 million, respectively.

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

During the three months ended March 31, 2020, we recorded net gains on sales, consolidation and deconsolidation of facilities of approximately \$2 million, primarily comprised of gains of \$11 million related to consolidation changes of certain USPI businesses due to ownership changes, partially offset by \$6 million of post-closing adjustments on the sale of three of our hospitals in the Chicago-area and \$3 million of post-closing adjustments on the sale of MacNeal Hospital.

During the three months ended March 31, 2019, we recorded net losses on sales, consolidation and deconsolidation of facilities of approximately \$1 million, primarily comprised of a \$7 million loss on the sale of our Chicago-area facilities, partially offset by \$5 million of gains related to consolidation changes of certain USPI businesses due to ownership changes, as well as post-closing adjustments on several other recent divestitures.

Interest Expense

Interest expense for the three months ended March 31, 2020 was \$243 million compared to \$251 million for the same period in 2019.

Loss From Early Extinguishment of Debt

Loss from early extinguishment of debt was \$47 million for the three months ended March 31, 2019. The loss in the 2019 period was due to the debt transactions described in Note 8 to the Consolidated Financial Statements in our Annual Report.

Income Tax Expense

During the three months ended March 31, 2020, we recorded an income tax benefit of \$75 million in continuing operations on pre-tax income of \$85 million compared to income tax expense of \$20 million on pre-tax income of \$84 million during the three months ended March 31, 2019. The reconciliation between the amount of recorded income tax expense and the amount calculated at the statutory federal tax rate is shown in the following table:

	Three Months Ended March 31,	
	2020	2019
Tax expense at statutory federal rate of 21%	\$ 18	\$ 18
State income taxes, net of federal income tax benefit	5	3
Tax attributable to noncontrolling interests	(14)	(17)
Nontaxable gains	3	(1)
Stock-based compensation	—	(1)
Change in valuation allowance	(90)	24
Other items	3	(6)
Income tax expense (benefit)	\$ (75)	\$ 20

As a result of the change in the business interest expense disallowance rules, as discussed in Note 14 to the accompanying Condensed Consolidated Financial Statements, we recorded an income tax benefit of \$91 million to decrease the valuation allowance for interest expense carryforwards due to the additional deduction of interest expense.

Net Income Available to Noncontrolling Interests

Net income available to noncontrolling interests was \$66 million for the three months ended March 31, 2020 compared to \$84 million for the three months ended March 31, 2019. Net income available (loss attributable) to noncontrolling interests for the three months ended March 31, 2020 was comprised of \$(7) million related to our Hospital Operations segment, \$57 million related to our Ambulatory Care segment and \$16 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, \$1 million related to the minority interests in USPI.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

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

“Adjusted EBITDA” is a non-GAAP measure defined by the Company as net income available (loss attributable) to Tenet Healthcare Corporation common shareholders before (1) the cumulative effect of changes in accounting principle, (2) net income available (loss attributable) to noncontrolling interests, (3) income (loss) from discontinued operations, net of tax, (4) income tax benefit (expense), (5) gain (loss) from early extinguishment of debt, (6) other non-operating income (expense), net, (7) interest expense, (8) litigation and investigation (costs) benefit, net of insurance recoveries, (9) net gains (losses) on sales, consolidation and deconsolidation of facilities, (10) impairment and restructuring charges and acquisition-related costs, (11) depreciation and amortization, and (12) income (loss) from divested and closed businesses (i.e., our health plan businesses). Litigation and investigation costs do not include ordinary course of business malpractice and other litigation and related expense.

The Company believes the foregoing non-GAAP measure is useful to investors and analysts because it presents additional information about the Company’s financial performance. Investors, analysts, Company management and the

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

The following table shows the reconciliation of Adjusted EBITDA to net income available (loss attributable) to Tenet Healthcare Corporation common shareholders (the most comparable GAAP term) for the three months ended March 31, 2020 and 2019:

	Three Months Ended March 31,	
	2020	2019
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	\$ 93	\$ (12)
Less: Net income available to noncontrolling interests	(66)	(84)
Income (loss) from discontinued operations, net of tax	(1)	8
Income from continuing operations	160	64
Income tax benefit (expense)	75	(20)
Loss from early extinguishment of debt	—	(47)
Other non-operating income, net	1	1
Interest expense	(243)	(251)
Operating income	327	381
Litigation and investigation costs	(2)	(13)
Net gains (losses) on sales, consolidation and deconsolidation of facilities	2	(1)
Impairment and restructuring charges, and acquisition-related costs	(55)	(19)
Depreciation and amortization	(203)	(208)
Loss from divested and closed businesses (i.e., the Company's health plan businesses)	—	(1)
Adjusted EBITDA	\$ 585	\$ 623
Net operating revenues	\$ 4,520	\$ 4,545
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders as a % of net operating revenues	2.1%	(0.3)%
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	12.9%	13.7 %

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

There have been no material changes to 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, as disclosed in our Annual Report, except for additional lease obligations and the long-term debt transactions disclosed in Notes 1 and 19, respectively, to our accompanying Condensed Consolidated Financial Statements.

At March 31, 2020, using the last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 5.44x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including the use of our revolving credit facility as a source of liquidity and acquisitions that involve the assumption of long-term debt. We seek to manage this ratio and increase the efficiency of our balance sheet by following our business plan and managing our cost structure, including through possible asset divestitures, and through other changes in our capital structure. As part of our long-term objective to manage our capital structure, we may issue

equity or convertible securities, and we may seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities, in each case subject to prevailing market conditions, our liquidity requirements, operating results, contractual restrictions and other factors. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Risk Factors section in Part II of this report and the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements, introduction of new medical technologies, design and construction of new buildings, and various other capital improvements, as well as commitments to make capital expenditures in connection with acquisitions of businesses. Capital expenditures were \$182 million and \$192 million in the three months ended March 31, 2020 and 2019, respectively. We have reduced our planned capital expenditures for 2020 by approximately 40%. We now anticipate that our capital expenditures for continuing operations for the year ending December 31, 2020 will total approximately \$400 million to \$450 million, including \$136 million that was accrued as a liability at December 31, 2019.

Interest payments, net of capitalized interest, were \$172 million and \$158 million in the three months ended March 31, 2020 and 2019, respectively.

Income tax payments, net of tax refunds, were \$3 million in the three months ended March 31, 2020 compared to income tax refunds, net of tax payments, of \$9 million in the three months ended March 31, 2019.

SOURCES AND USES OF CASH

Our liquidity for the three months ended March 31, 2020 was primarily derived from net cash provided by operating activities, cash on hand and borrowings under our revolving credit facility. We had \$613 million of cash and cash equivalents on hand at March 31, 2020 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was \$999 million based on our borrowing base calculation at March 31, 2020.

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

Net cash provided by operating activities was \$129 million in the three months ended March 31, 2020 compared to \$10 million in the three months ended March 31, 2019. Key factors contributing to the change between the 2020 and 2019 periods include the following:

- \$74 million less cash used in the 2020 period for the annual 401(k) match funding;
- An increase of \$36 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- The timing of other working capital items.

Net cash used in investing activities was \$204 million for the three months ended March 31, 2020 compared to \$139 million for the three months ended March 31, 2019. The 2020 amount included \$53 million of additional investments for purchases of businesses or joint venture interests compared to the 2019 period. The 2019 period included proceeds from sales of facilities and other assets of \$41 million due to the sale of three hospitals and hospital-affiliated operations in the Chicago area. Capital expenditures were \$182 million and \$192 million in the three months ended March 31, 2020 and 2019, respectively.

Net cash provided by financing activities was \$426 million for the three months ended March 31, 2020 compared to net cash used in financing activities of \$30 million for the three months ended March 31, 2019. The 2020 amount included net borrowings under our credit facility of \$500 million described in Note 6 to our accompanying Condensed Consolidated Financial Statements. The 2019 amount included proceeds from the issuance of \$1.5 billion aggregate principal amount of 6.250% senior secured second lien notes due 2027, as well as the payments for our purchases of \$300 million aggregate principal amount of our outstanding 6.750% senior notes due 2020, \$750 million aggregate principal amount of our outstanding 7.500% senior secured second lien notes due 2022, and \$468 million aggregate principal amount of our outstanding 5.500% senior unsecured notes due 2019. The 2019 amount also included net borrowings under our credit facility of \$190 million.

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

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

Credit Agreement. We have a senior secured revolving credit facility that, at March 31, 2020, provided for revolving loans in an aggregate principal amount of up to \$1.5 billion with a \$200 million subfacility for standby letters of credit. At March 31, 2020, we had \$500 million of cash borrowings outstanding under the revolving credit facility subject to a weighted average interest rate of 1.894%, and we had \$1 million of standby letters of credit outstanding. Based on our eligible receivables, \$999 million was available for borrowing under the revolving credit facility at March 31, 2020. At March 31, 2020, we were in compliance with all covenants and conditions in our senior secured revolving credit facility.

On April 24, 2020, we amended our credit agreement (as amended, the “Credit Agreement”) to, among other things, (i) increase the aggregate revolving credit commitments from \$1.5 billion to \$1.9 billion, subject to borrowing availability, and (ii) increase the advance rate and raise limits on certain eligible accounts receivable in the calculation of the borrowing base, in each case, for an incremental period of 364 days. For additional information regarding the Credit Agreement, see Note 6 to the accompanying Condensed Consolidated Financial Statements.

Letter of Credit Facility. In March 2020, we amended our letter of credit facility (as amended, the “LC Facility”) to extend the scheduled maturity date of the LC Facility from March 7, 2021 to September 12, 2024 and to increase the aggregate principal amount of standby and documentary letters of credit that from time to time may be issued thereunder from \$180 million to \$200 million. Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes. At March 31, 2020, we were in compliance with all covenants and conditions in our LC Facility. At March 31, 2020, we had \$91 million of standby letters of credit outstanding under the LC Facility.

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

For additional information regarding our long-term debt, see Note 6 to the accompanying Condensed Consolidated Financial Statements and Note 7 to the Consolidated Financial Statements included in our Annual Report.

LIQUIDITY

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

While demand for our services is expected to rebound in the future, we have taken, and continue to take, various actions to increase our liquidity and mitigate the impact of reductions in our patient volumes and operating revenues from the COVID-19 pandemic. In April 2020, we sold \$700 million aggregate principal amount of our 2025 Senior Secured First Lien Notes, a portion of the proceeds of which were used to repay borrowings outstanding under our Credit Agreement. In addition, we amended our Credit Agreement in April 2020 to increase our borrowing availability and make certain changes with respect to the calculation of our borrowing base. We also reduced our planned capital expenditures for 2020 by approximately 40%. Furthermore, we have furloughed some employees, and we have deferred certain operating expenses that are not expected to impact our response to COVID-19. We are also reducing variable costs across the enterprise as a result of softening patient volumes. We believe these actions, together with government relief programs intended to mitigate increases in expenses and lost revenue attributable to the COVID-19 pandemic, will help us to continue operating during these uncertain times. As more fully described under “Sources of Revenue for Our Hospital Operations Segment – Government Programs” above:

- The Medicare Fee-for-Service accelerated and advanced payment program has been expanded. Our hospitals, ambulatory surgery centers, physician practices and other outpatient facilities received approximately \$1.500 billion of accelerated payments under this program in April 2020.
- Beginning March 27, 2020, all employers may elect to defer payment of the 6.2% employer Social Security tax through December 31, 2020. Deferred tax amounts are required to be paid in equal amounts over two years, with payments due in December 2021 and December 2022. We expect that we will defer approximately \$250 million of taxes in 2020 pursuant to this CARES Act provision.
- \$100 billion has been authorized under the CARES Act for the PHSS Emergency Fund, which is intended to support healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic and to ensure uninsured Americans can get testing and treatment for COVID-19, with \$50 billion allocated for general distribution to certain eligible healthcare providers. Based on our share of total Medicare FFS reimbursements in 2019, we received PHSS Emergency Fund payments of approximately \$225 million in mid-April 2020. Based on our share of 2018 net patient revenue, we estimate we will receive additional payments of approximately \$145 million. As a result, we estimate we will receive total payments of approximately \$370 million from the total \$50 billion general distribution to eligible healthcare providers. Payments from the PHSS Emergency Fund are not loans and, therefore, they are not subject to repayment. However, as a condition to receiving PHSS Emergency Fund payments, providers must submit sufficient documentation demonstrating that the funds are being used for healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic. In addition, providers must agree to certain terms and conditions.
- Effective May 1, 2020, the annual 2% sequestration revenue reduction in Medicare FFS and Medicare Advantage payments to hospitals, physicians and other providers will be suspended for the rest of CY 2020. The projected impact of this change on our operations is an increase of approximately \$67 million of revenues in 2020, which is not subject to repayment.
- The scheduled reduction of \$4 billion in Medicaid DSH payments in FFY 2020, as mandated by the Affordable Care Act, will be suspended until December 1, 2020. The projected impact of this change on our operations is an increase of approximately \$60 million in revenues in 2020, which is not subject to repayment.

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

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest payments. Cash flows from operating activities in the first quarter of the calendar year are usually lower than in subsequent quarters of the year, primarily due to the timing of certain working capital requirements during the first quarter, including our annual 401(k) matching contributions and annual incentive compensation payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that have caused, and in the future will cause, us to use our Credit Agreement as a source of liquidity. We believe that existing cash and cash equivalents on hand, borrowing availability under our Credit Agreement, anticipated future cash provided by government relief packages and our operating activities should be adequate to meet our current cash needs. These sources of liquidity, in combination with any potential future debt incurrence, should also be adequate to finance planned capital expenditures, payments on the current portion of our long-term debt, payments to joint venture partners, including those related to put and call arrangements, and other presently known operating needs.

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

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our period-end balance sheets. In addition, we

do not have significant exposure to floating interest rates given that all of our current long-term indebtedness has fixed rates of interest except for borrowings under our Credit Agreement.

OFF-BALANCE SHEET ARRANGEMENTS

We have no off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for \$192 million of standby letters of credit outstanding and guarantees at March 31, 2020.

CRITICAL ACCOUNTING ESTIMATES

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

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

Our critical accounting estimates have not changed from the description provided in our Annual Report.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

	Maturity Date, Years Ending December 31,							Total	Fair Value
	2020	2021	2022	2023	2024	Thereafter			
	(Dollars in Millions)								
Fixed rate long-term debt	\$ 165	\$ 120	\$ 2,858	\$ 1,904	\$ 2,488	\$ 7,389	\$ 14,924	\$ 14,190	
Average effective interest rates	4.7%	5.2%	8.6%	7.4%	4.9%	5.8%	6.3%		
Variable rate long-term debt	\$ —	\$ —	\$ —	\$ —	\$ 500	\$ —	\$ 500	\$ 500	
Average effective interest rates	—	—	—	—	1.9%	—	1.9%		

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

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

ITEM 4. CONTROLS AND PROCEDURES

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the “Exchange Act”), as of the end of the period covered by this report. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Exchange Act and the SEC rules thereunder.

There were no changes in our internal control over financial reporting during the quarter ended March 31, 2020 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. 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 12 to our accompanying Condensed Consolidated Financial Statements, which is incorporated by reference.

ITEM 1A. RISK FACTORS

There have been no material changes to the risk factors discussed in our Annual Report on Form 10-K for the year ended December 31, 2019 (“Annual Report”), except that the following risk factor has been updated to reflect the heightened impact in the United States of the novel coronavirus (“COVID-19”) pandemic since we filed our Annual Report.

The COVID-19 pandemic is significantly affecting our operations and financial condition, and our liquidity could also be negatively impacted, particularly if the U.S. economy remains unstable for a significant period of time.

The spread of COVID-19 and the ensuing response of federal, state and local authorities beginning in March 2020 resulted in a material reduction in our patient volumes and operating revenues that is ongoing. Known and unknown risks and uncertainties caused by the COVID-19 pandemic, including those described below, are having, and will likely continue to have, a material impact on our business, financial condition, results of operations and cash flows. Because the ultimate extent and scope of the COVID-19 pandemic is unknown, the risks and uncertainties described in our Annual Report may also be heightened.

We have taken measures within the communities we serve, both voluntarily and in accordance with governmental mandates, to try to limit the spread of the virus and to mitigate the burden on the healthcare system. Many of these measures will have an adverse impact on our business and financial results that we are not currently able to fully quantify. We have cancelled a substantial number of elective procedures at our hospitals and closed or reduced operating hours at our ambulatory surgery centers and other outpatient centers that specialize in elective procedures. Restrictive measures, including travel bans, social distancing, quarantines and shelter-in-place orders, have also reduced the volume of procedures performed at our facilities more generally, as well as the volume of emergency room and physician office visits. As states and localities stabilize and restrictive measures are lifted, we will begin to re-open our closed facilities and offer more non-emergent, non-COVID-19 healthcare services, including surgeries and other procedures, chronic disease management and, ultimately, preventative care, throughout our network in accordance with guidelines from the Centers for Medicare and Medicaid Services and other agencies. Given the geographic diversity of our operations, we expect some localities to be open more quickly than others, and we cannot predict when all of our facilities will be fully operational. Moreover, if an area in which we operate experiences a surge in COVID-19 cases, we may be forced to reduce services once more. Any federal, state or local law, regulation, order or other action imposing direct or indirect restrictions on our business due to the COVID-19 pandemic or otherwise may have an adverse impact on our financial condition, results of operations and cash flows.

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

We are also experiencing supply chain disruptions, including shortages, delays and significant price increases in medical supplies, particularly personal protective equipment. These shortages and delays may impact our ability to see, admit and treat patients.

Broad economic factors resulting from the COVID-19 pandemic, including increasing unemployment rates and reduced consumer spending, are impacting our service mix, revenue mix and patient volumes. Business closings and layoffs in the areas we operate may lead to increases in the uninsured and underinsured populations and adversely affect demand for our services, as well as the ability of patients to pay for services as rendered. Any increase in the amount of or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations. If general economic conditions continue to deteriorate or remain uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be impacted. We may be required to engage in capital markets and other financing activities to remain operational. There can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

ITEM 6. EXHIBITS

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

- (4) Instruments Defining the Rights of Security Holders, Including Indentures
 - (a) [Thirty-Fourth Supplemental Indenture, dated as of April 7, 2020, among the Registrant, the guarantors party thereto and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 7.500% Senior Secured First Lien Notes Due 2025 \(Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K filed April 7, 2020\)](#)
- (10) Material Contracts
 - (a) [Amendment No. 5, dated as of April 24, 2020, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto and Citicorp USA, Inc., as administrative agent \(Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed April 27, 2020\)](#)
 - (b) [Amendment No. 4, dated as of March 19, 2020, to the Letter of Credit Facility Agreement, dated as of March 7, 2014, by and among the Registrant, the LC participants and issuers party thereto and Barclays Bank PLC, as administrative agent \(Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed March 24, 2020\)](#)
 - (c) [Exchange and Registration Rights Agreement, dated as of April 7, 2020, among the Registrant, the guarantors party thereto and Barclays Capital Inc. as representative of the other initial purchasers of the notes named therein \(Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed April 7, 2020\)](#)
 - (d) [Amendment No. 2 to Employment Agreement, dated as of February 26, 2020 \(Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K filed February 28, 2020\)*](#)
 - (e) [Letter from the Registrant to Paola Arbour, dated May 3, 2018*](#)
- (18) [Letter from Deloitte & Touche LLP Regarding Change in Accounting Principle](#)
- (31) Rule 13a-14(a)/15d-14(a) Certifications
 - (a) [Certification of Ronald A. Rittenmeyer, Executive Chairman and Chief Executive Officer](#)
 - (b) [Certification of Daniel J. Cancelmi, Executive Vice President and Chief Financial Officer](#)
- (32) [Section 1350 Certification of Ronald A. Rittenmeyer, Executive Chairman and Chief Executive Officer, and Daniel J. Cancelmi, Executive Vice President and Chief Financial Officer](#)
- (101 SCH) Inline XBRL Taxonomy Extension Schema Document
- (101 CAL) Inline XBRL Taxonomy Extension Calculation Linkbase Document
- (101 DEF) Inline XBRL Taxonomy Extension Definition Linkbase Document
- (101 LAB) Inline XBRL Taxonomy Extension Label Linkbase Document
- (101 PRE) Inline XBRL Taxonomy Extension Presentation Linkbase Document
- (101 INS) Inline XBRL Taxonomy Extension Instance Document - the instance document does not appear in the interactive data file because its XBRL tags are embedded within the inline XBRL document.
- (104) Cover page from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020 formatted in Inline XBRL (included in Exhibit 101)

* Management contract or compensatory plan or arrangement.

[TENET HEALTHCARE LETTERHEAD]

May 3, 2018

Paola Arbour
[Home Address Line 1]
[Home Address Line 2]

RE: Position of Senior Vice President, Chief Information Officer

Dear Paola,

It has been a great pleasure for me and other colleagues at Tenet Healthcare Corporation to get to know you and learn more about your impressive accomplishments. I believe you would be an outstanding addition to our leadership team and would bring fresh perspectives to the company. We also believe you would be a great collaborative partner, which is very important to me personally.

That's why I am pleased to offer you the position of Senior Vice President, Chief Information Officer at Tenet, effective May 21, 2018. In this role, you will report to me directly and work at our headquarters in Dallas, Texas.

Tenet's mission is to help people live happier, healthier lives. Employees across our system are committed to this mission, every day. If you appreciate our mission as much as we do and want to make a lasting impact in our diverse healthcare organization, then I look forward to welcoming you to Tenet. I am glad you consider Tenet an employer where you would be proud to lead and apply your professional expertise.

The following pages provide details about compensation and benefits for which you are eligible as a Tenet executive. To accept this offer, please sign and return to paul.slavin@tenethealth.com.

Best regards,

Ron Rittenmeyer
Executive Chairman and CEO

Enclosure

cc: Sandi Karmann, SVP, Chief Human Resource Officer

Tenet Employment, Inc. ("Tenet") herein provides to Paola Arbour effective May 21, 2018 the following compensation and benefits. As Tenet's Senior Vice President, Chief Information Officer at the home office located in Dallas, TX, you will report to Ron Rittenmeyer, Executive Chairman and Chief Executive Officer.

Compensation & Benefits

- A. Base Salary: You will receive an annual exempt rate of \$500,000 payable bi-weekly.
- B. Sign-On Cash Bonus: You will receive a bonus of \$100,000 (*subject to applicable taxes*) to be paid with your first paycheck. If you resign or are terminated from employment within two years after receipt of the payment for reasons unrelated to a Qualifying Termination, you will be required to reimburse Tenet for all monies paid to you or on your behalf. If payback is required, you will be advised in writing of the exact amount and payment will be due within 90 days of your last day worked. The amount due will be based on the following schedule:
- i. Termination Within Less Than One Year: 100% of Bonus
 - ii. Termination Within One to Two Years: 50% of Bonus
- C. Annual Incentive Plan (AIP): Your target award is 75% of your base salary, and the actual result is based on your performance vs. targets using the metrics of Tenet's balanced score card. Actual payouts from the AIP can vary from 0% to 200% of target.
- D. Health & Welfare Benefits: You will be able to participate in Tenet's competitive benefit packages after 30 days of employment with the company. A detailed listing of benefits will be provided to you through the company's on-boarding website.
- E. Manager's Time-Off Plan (MTO): You will receive a maximum of four weeks of paid time off and nine paid holidays per year.
- F. Deferred Compensation Plan (DCP): You will be eligible to participate in the DCP which provides pre-tax compensation deferral options, some of which are eligible for a company match. You will have 30 days from your start date to enroll. You will receive a communication from the Executive Compensation Department following the effective date of your employment which includes complete details about the DCP.
- G. Stock Incentive Plan (SIP): You will be eligible for an annual incentive award which typically occurs in the first quarter of the year. Each year, eligibility and award value are subject to the review and approval of the company's Human Resources Committee of the Board of Directors. Eligibility does not guarantee an award will be made.
- For the 2018 plan year, you will receive long term incentive awards totaling \$800,000. This award will be granted on the last business day of the month of your start date, June 29, 2018, and includes a combination of performance-based stock options, performance-based cash incentives and service-based restricted stock units. You will receive a separate communication from Fidelity Investments, Tenet's stock plan record keeper, containing more details about the award and three on-line agreements which you will need to accept in order for the award to vest.
- H. Executive Severance Plan (ESP): You will be eligible to participate in the Tenet ESP which provides certain benefits including Severance Pay which totals the sum of one and one-half years of your annual base salary plus target annual bonus in the event of a Qualifying Termination as defined in the Plan. You will receive a communication from the Executive Compensation Department following

the effective date of your employment which includes complete details about the ESP and an Agreement requiring your signature.

- I. Executive Retirement Account (ERA): You will receive an annual credit equal to twenty percent (20%) of your base salary while you are employed in a position that is eligible for benefits under the plan. The first credit will occur on the next annual company contribution date in July 2018. You will receive a communication from the Executive Compensation Department following the effective date of your employment which includes complete details about the ERA and an election you may make within 30 days of your eligibility.

Terms and Conditions of Employment

This offer is contingent upon satisfactory completion of a pre-work drug screening exam, a background investigation, reference checks and the acceptance of the ensuing terms and conditions.

Your employment with Tenet will be on an at-will basis, which means that either you or the company may terminate the employment relationship, with or without notice and with or without cause at any time. As used in this letter, the term "cause" shall include, but shall not be limited to, dishonesty, fraud, willful misconduct, self-dealing or violations of the Tenet Standards of Conduct, breach of fiduciary duty (whether or not involving personal profit), failure, neglect or refusal to perform your duties in any material respect, violation of law (except traffic violations or similar minor infractions), violation of Tenet's Human Resources or other Policies, or any material breach of this letter.

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

Ethics & Compliance: You agree to attend Ethics & Compliance classes within established Tenet policy guidelines, as well as a refresher course every year.

Standards of Conduct: You agree to abide by Tenet's Standards of Conduct, which reflect Tenet's basic values of high-quality, cost-effective health services; honesty, trustworthiness, and reliability in all relationships; leadership in the development of partnership arrangements with providers of health services; good corporate citizenship in the communities where Tenet provides services; pursuit of fiscal responsibility and growth; compliance with all applicable rules, regulations, policies and procedures; and fair treatment of employees.

Conflict Resolution: You agree to abide by Tenet's Fair Treatment Process which includes final and binding Arbitration as a resolution to any grievance that results from your employment or termination of employment with Tenet.

Confidentiality, Non-Compete and Non-Interference Agreement

In your position at Tenet you will be involved in building and maintaining business relationships and goodwill on behalf of Tenet with customers, patients, physicians and other professional contractors, employees and staff, and various providers and users of health care services. You will also be entrusted with proprietary, strategic and other confidential information which is of special value to Tenet. You agree that all confidential information that comes into your possession by reason of your employment is the property of Tenet and shall not be used except in the course of employment by Tenet and for Tenet's exclusive benefit. During your employment or thereafter you understand that you will not disclose or acknowledge the content of any confidential information to any person who is not an employee of Tenet authorized to possess such confidential information. "Confidential information" means all proprietary and other information relating to the business and operations of Tenet which has not been specifically designated for release to the public by an authorized representative of Tenet. Confidential information includes, by way of illustration and without limitation, trade

secrets, business plans, marketing plans and strategies, pricing information, financial data, customer, patient and supplier information, employee information, regulatory approval strategies, new service line and contract products, and other information that was developed, assembled, gathered by, or originated with Tenet for its own private use.

During your employment and for a period of twelve (12) months after the end of your employment with Tenet, in exchange for the offer of employment or promotion accompanying this agreement and the receipt of the confidential information over the course of your employment, you agree that you will not compete, directly or indirectly, with Tenet by doing work in a service line in which you provide services for Tenet within the last six (6) months prior to your separation from the company. "Compete" means and includes rendering services, accepting employment, consultation, or any other business relationship with any company, association, affiliation, consortium, or other for-profit or not-for-profit organization that provides or offers health care services or contracts or agreements for health care services similar to those provided or offered by Tenet.

You also agree that during the period of your employment and for twelve (12) months after the end of your employment Tenet, you will not directly or indirectly disrupt, damage, impair or interfere with the business of Tenet or the business of any facility for which you performed services during the 12 months prior to your separation from service, whether by way of interfering with, soliciting or raiding its employees, disrupting its relationships with physicians, patients, customers, vendors, contractors, professional health care providers or provider organizations, businesses, persons or entities or otherwise.

This agreement shall apply irrespective of the reason you may leave Tenet and is independent of any similar provisions contained in any severance agreement. You acknowledge and agree that you consider the restrictions set forth above to be reasonable both individually and in the aggregate, and that the time, geographic scope, extent and application of each of these restrictions is no greater than is necessary to protect Tenet's legitimate interests. It is your and Tenet's intent and desire that this agreement shall be enforced to the fullest extent possible under the laws and public policies applied in each jurisdiction in which enforcement is sought. Tenet and you further agree that if any particular provision or portion of this agreement is adjudicated to be invalid or unenforceable, that decision shall apply only with respect to the operation of that provision in the particular jurisdiction in which the adjudication was made. Tenet and you also agree that in the event that any restriction herein is found to be void or unenforceable but would be valid or enforceable if some part or parts thereof were deleted or the period or area of application reduced, such restriction shall apply with such modification as may be necessary to make it valid, and you and Tenet empower a court or arbitrator hereunder of competent jurisdiction, to modify, reduce or otherwise reform such provision(s) in such fashion as to carry out the parties' intent to grant Tenet the maximum allowable protection consistent with the applicable law and facts.

The parties agree that no provision of this Agreement shall be construed or interpreted in any way to limit, restrict or preclude either party hereto from cooperating and communicating with any governmental agency in the performance of its investigatory or other lawful duties.

Tenet Employment, Inc.

/s/ Paul Slavin _____ Date: May 3, 2018

Paul Slavin
Vice President, Total Rewards & Workforce Analytics

Acknowledged and Accepted:

/s/ Paola Arbour _____ Date: May 5, 2018

May 4, 2020

Tenet Healthcare Corporation

14201 Dallas Parkway
Dallas, TX 75254

Dear Sirs/Madams:

At your request, we have read the description included in your Quarterly Report on Form 10-Q to the Securities and Exchange Commission for the quarter ended March 31, 2020, of the facts relating to the change in the Company's method of accounting for its professional and general liability reserves from recording those reserves at a discounted amount to recording them at an undiscounted amount. We believe, on the basis of the facts so set forth and other information furnished to us by appropriate officials of Tenet Healthcare Corporation, that the accounting change described in your Form 10-Q is to an alternative accounting principle that is preferable under the circumstances.

We have not audited any consolidated financial statements of Tenet Healthcare Corporation and its subsidiaries as of any date or for any period subsequent to December 31, 2019. Therefore, we are unable to express, and we do not express, an opinion on the facts set forth in the above-mentioned Form 10-Q, on the related information furnished to us by officials of the Tenet Healthcare Corporation, or on the financial position, results of operations, or cash flows of Tenet Healthcare Corporation and its subsidiaries as of any date or for any period subsequent to December 31, 2019.

Yours truly,

/s/ DELOITTE & TOUCHE LLP

Rule 13a-14(a)/15d-14(a) Certification

I, Ronald A. Rittenmeyer, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Tenet Healthcare Corporation (the “Registrant”);
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;
4. The Registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the Registrant’s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the Registrant’s internal control over financial reporting that occurred during the Registrant’s most recent fiscal quarter (the Registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant’s internal control over financial reporting; and
5. The Registrant’s other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant’s auditors and the audit committee of the Registrant’s board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant’s ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant’s internal control over financial reporting.

Date: May 4, 2020

/s/ RONALD A. RITTENMEYER

Ronald A. Rittenmeyer

Executive Chairman and Chief Executive Officer

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Tenet Healthcare Corporation (the “Registrant”);
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;
4. The Registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the Registrant’s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the Registrant’s internal control over financial reporting that occurred during the Registrant’s most recent fiscal quarter (the Registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant’s internal control over financial reporting; and
5. The Registrant’s other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant’s auditors and the audit committee of the Registrant’s board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant’s ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant’s internal control over financial reporting.

Date: May 4, 2020

/s/ DANIEL J. CANCELMI

Daniel J. Cancelmi

Executive Vice President and Chief Financial Officer

**Certifications Pursuant to Section 1350 of Chapter 63
of Title 18 of the United States Code**

We, the undersigned Ronald A. Rittenmeyer and Daniel J. Cancelmi, being, respectively, the Executive Chairman and Chief Executive Officer and the Executive Vice President and Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020 (the "Form 10-Q"), to be filed with the Securities and Exchange Commission on the date hereof, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, and (ii) the information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: May 4, 2020

/s/ RONALD A. RITTENMEYER

Ronald A. Rittenmeyer

Executive Chairman and Chief Executive Officer

Date: May 4, 2020

/s/ DANIEL J. CANCELMI

Daniel J. Cancelmi

Executive Vice President and Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.