FOLEY
FOLEY & LARDNER LLP

ATTORNEYS AT LAW
321 NORTH CLARK STREET, SUITE 2800
CHICAGO, IL 60654-5313
312.832.4500 TEL
312.832.4700 FAX
WWW.FOLEY.COM

WRITER'S DIRECT LINE
312.832.4375
egreen@foley.com EMAIL

CLIENT/MATTER NUMBER
026141-0144

Via FedEx

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761-0001

Re: Certificate of Exemption (Change of Ownership)
Project: Silver Cross Ambulatory Surgery Center (New Lenox, Illinois)

Dear Mr. Constantino:

Enclosed please find an original and one copy of the Certificate of Exemption (Change of Ownership) regarding the Silver Cross Ambulatory Surgery Center in New Lenox, Illinois. Also enclosed is a check in the amount of $2,500 to cover the application processing fee.

Please feel free to contact me if you have any questions.

Sincerely,

Edward J. Green

EJGR:sc
Encls.

E-029-17

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

RECEIVED
JUN 27 2017
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Silver Cross Ambulatory Surgery Center
Street Address: Southwest Corner of Route 6 and Silver Cross Boulevard
City and Zip Code: New Lenox, Illinois 60451
County: Will Health Service Area: 009 Health Planning Area: 009

Applicant(s) [Provide for each co-applicant (refer to Part 1130.220)]

Exact Legal Name: Silver Cross Ambulatory Surgery Center LLC
Street Address: 1900 Silver Cross Boulevard
City and Zip Code: New Lenox, Illinois 60451
Name of Registered Agent: John Krepps
Registered Agent Street Address: 1900 Silver Cross Boulevard
Registered Agent City and Zip Code: New Lenox, Illinois 60451
Name of Chief Executive Officer: Paul Pawlak
CEO Street Address: 1900 Silver Cross Boulevard
CEO City and Zip Code: New Lenox, Illinois 60451
CEO Telephone Number: (815) 300-4965

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Silver Cross Ambulatory Surgery Center
Street Address: Southwest Corner of Route 6 and Silver Cross Boulevard
City and Zip Code: New Lenox, Illinois 60451
County: Will Health Service Area: 009 Health Planning Area: 009

Applicant(s) [Provide for each co-applicant (refer to Part 1130.220)]

Exact Legal Name: Silver Cross Hospital and Medical Centers
Street Address: 1900 Silver Cross Boulevard
City and Zip Code: New Lenox, Illinois 60451
Name of Registered Agent: Paul Pawlak
Registered Agent Street Address: 1900 Silver Cross Boulevard
Registered Agent City and Zip Code: New Lenox, Illinois 60451
Name of Chief Executive Officer: Paul Pawlak
CEO Street Address: 1900 Silver Cross Boulevard
CEO City and Zip Code: New Lenox, Illinois 60451
CEO Telephone Number: (815) 300-4965

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Silver Cross Ambulatory Surgery Center		
Street Address: Southwest Corner of Route 6 and Silver Cross Boulevard		
City and Zip Code: New Lenox, Illinois 60451		
County: Will	Health Service Area: 009	Health Planning Area: 009

Applicant(s) [Provide for each co-applicant (refer to Part 1130.220)]

Exact Legal Name: USP Silver Cross, Inc.
Street Address: 15305 Dallas Parkway, Suite 1600
City and Zip Code: Addison, Texas, 75001
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago, Illinois 60604
Name of Chief Executive Officer: William H. Wilcox
CEO Street Address: 15305 Dallas Parkway, Suite 1600
CEO City and Zip Code: Addison, Texas, 75001
CEO Telephone Number: (972) 713-3500

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Silver Cross Ambulatory Surgery Center
Street Address: Southwest Corner of Route 6 and Silver Cross Boulevard
City and Zip Code: New Lenox, Illinois 60451
County: Will Health Service Area: 009 Health Planning Area: 009

Applicant(s) [Provide for each co-applicant (refer to Part 1130.220)]

Exact Legal Name: Silver Cross/USP Surgery Center LLC
Street Address: 15305 Dallas Parkway, Suite 1600
City and Zip Code: Addison, Texas, 75001
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago, Illinois 60604
Name of Chief Executive Officer: William H. Wilcox
CEO Street Address: 15305 Dallas Parkway, Suite 1600
CEO City and Zip Code: Addison, Texas, 75001
CEO Telephone Number: (972) 713-3500

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Silver Cross Ambulatory Surgery Center
Street Address: Southwest Corner of Route 6 and Silver Cross Boulevard
City and Zip Code: New Lenox, Illinois 60451
County: Will Health Service Area: 009 Health Planning Area: 009

Applicant(s) [Provide for each co-applicant (refer to Part 1130.220)]

Exact Legal Name: USPI Holding Company, Inc.
Street Address: 15305 Dallas Parkway, Suite 1600
City and Zip Code: Addison, Texas, 75001
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago, Illinois 60604
Name of Chief Executive Officer: William H. Wilcox
CEO Street Address: 15305 Dallas Parkway, Suite 1600
CEO City and Zip Code: Addison, Texas, 75001
CEO Telephone Number: (972) 713-3500

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☒ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

Additional Contact

[Person who is also authorized to discuss the application for exemption permit]

Name: Ruth Colby
Title: Senior Vice President, Chief Strategy Officer
Company Name: Silver Cross Hospital & Medical Centers
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Telephone Number: (815) 300-7002
E-mail Address: rcolby@silvercross.org
Fax Number: (815) 300-7047

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name: Ruth Colby
Title: Senior Vice President, Chief Strategy Officer
Company Name: Silver Cross Hospital & Medical Centers
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Telephone Number: (815) 300-7002
E-mail Address: rcolby@silvercross.org
Fax Number: (815) 300-7047

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Silver Cross Hospital & Medical Centers
Address of Site Owner: 1900 Silver Cross Boulevard, New Lenox, Illinois 60451
Street Address or Legal Description of Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Silver Cross Ambulatory Center LLC
Address: 1900 Silver Cross Boulevard, New Lenox, Illinois 60654
☐ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☒ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☒ Change of Ownership
- ☐ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Silver Cross Hospital and Medical Centers ("Silver Cross Hospital"), Silver Cross Ambulatory Surgery Center LLC ("SCASC"), USP Silver Cross, Inc. ("USP"), USPI Holding Company, Inc. ("USPI"), and Silver Cross/USP Surgery Center LLC (the "Joint Venture," and collectively with Silver Cross Hospital, SCASC, USP and USPI, the "Applicants") are proposing a change of ownership for Silver Cross Ambulatory Surgery Center (the "Silver Cross Surgery Center"), a multi-specialty surgery center currently under construction in New Lenox, Illinois.

More specifically, the Applicants hereby seek a Certificate of Exemption (Change of Ownership) from the Illinois Health Facilities and Services Review Board (the "Review Board") to allow consummation of a series of transactions pursuant to which Silver Cross Hospital would contribute its current ownership interest in SCASC (which owns the Silver Cross Surgery Center) to the Joint Venture and USP would contribute One Million, One Hundred Twenty Four Thousand, Two Hundred Forty Four Dollars ($1,124,244) to the Joint Venture, thereby resulting in Silver Cross Hospital reducing its current ownership in SCASC from 52% (directly) to 25.45% (indirectly, by virtue of its ownership interest in the Joint Venture) and USP increasing its ownership in SCASC from 0% to 25.55% (indirectly, by virtue of its ownership interest in the Joint Venture) (the "Transactions").

Background Facts

On or about May 17, 2016, Silver Cross Hospital and SCASC filed a Certificate of Need Application (the "Surgery Center CON Application") with the Review Board to develop and establish the Silver Cross Ambulatory Surgery Center (the "Silver Cross Surgery Center") on Silver Cross' campus in New Lenox, Illinois. See Project No. 16-021.

In the Surgery Center CON Application, Silver Cross Hospital and SCASC stated that "SCASC intends to sell up to forty nine percent (49%) of the membership units in SCASC to physicians (the "Syndication"). No physician will be allowed to purchase more than a two and one-half percent (2.5%) interest in SCASC. Prior to the Syndication, SCASC and Silver Cross Hospital will also enter into a fair market value lease for the Surgery Center Facility. SCASC may also contract with a management company to provide management services at the Surgery Center. If a management company is ultimately engaged, and the management company seeks ownership as part of its management agreement, thereby decreasing Silver Cross Hospital's interest in SCASC below fifty percent (50%), the Applicants will file a Certificate of Need (Change of Ownership) Application with the Board." See Surgery Center CON Application at page 5.

On or about September 13, 2016, the Review Board approved the Surgery Center CON Application.

On or about October 20, 2016, Silver Cross Hospital and SCASC began the process of syndicating SCASC to various physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit.

On or about November 20, 2016, Silver Cross Hospital and SCASC successfully syndicated SCASC, and effective as of January 1, 2017, Silver Cross Hospital sold/transferred forty seven percent (47%) of its membership interests (representing 94 membership units) in

SCASC to certain physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit.

On or about February 9, 2017, Silver Cross Hospital and USP, an affiliate of USPI, organized the Joint Venture.

On or about March 10, 2017, Silver Cross Hospital and SCASC sold/transferred an additional one percent (1%) of its membership interests (representing 2 membership interests) in SCASC to certain physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit. Thus, as of today's date, physicians on the medical staff at Silver Cross Hospital own 48% of the membership units (representing 96 membership units) in SCASC (collectively, the "Physician Members') and Silver Cross Hospital owns 52% of the membership units (representing 104 membership units) in SCASC.

On or about March 31, 2017, SCASC and USP entered into that certain Management Agreement (the "Management Agreement") pursuant to which USP agreed to manage the Silver Cross Surgery Center.

On or about March 31, 2017, Silver Cross Hospital and USP entered into that certain Contribution Agreement (the "Contribution Agreement") pursuant to which: (a) Silver Cross Hospital agreed to transfer and contribute 102 membership units in SCASC to the Joint Venture (the "Transferred Interest"), pursuant to the terms and conditions set forth in the Contribution Agreement; and (b) USP agreed to transfer and contribute One Million, One Hundred Twenty Four Thousand, Two Hundred Forty Four Dollars ($1,124,244) (which represents a per unit price of $22,000) to the Joint Venture, which amount will, in turn, be paid to Silver Cross Hospital in consideration for Silver Cross Hospital's transfer of the Transferred Interest to the Joint Venture, pursuant to the terms and conditions set forth in the Contribution Agreement. The Contribution Agreement also contemplates that Silver Cross Hospital will sell an additional 2 membership units in SCASC to the Physician Members (or another physician on the medical staff at Silver Cross Hospital) prior to the closing of the Transactions, as contemplated by the Management Agreement and the Contribution Agreement.

The Transactions will reduce Silver Cross Hospital's ownership interest in SCASC below fifty percent (50%), thereby triggering the obligation to file a Certificate of Exemption (Change of Ownership) with the Review Board. Accordingly, the Transactions will only become effective once the Transactions are approved by the Review Board.

Following the closing of the Transactions, Physician Members will own 49% of SCASC and the Joint Venture will own 51% of SCASC. And USP will own 50.1% of the Joint Venture and Silver Cross Hospital will own 49.9% of the Joint Venture – which, means Silver Cross Hospital will indirectly own 25.45% of SCASC (by virtue of its ownership interest in the Joint Venture) and USP will indirectly own 25.55% of SCASC (by virtue of its ownership interest in the Joint Venture).

The Transactions will close upon the approval of this Certificate of Exemption (Change of Ownership) by the Review Board.

The Project is classified as non-substantive because it proposes a change of ownership which constitutes a facility conversion pursuant to 77 Ill. Admin. Code 1140.40(b).

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ ____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): Upon approval by Board (July 14, 2017).

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Silver Cross Ambulatory Surgery Center LLC * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Paul Pawlak
PRINTED NAME

President & CEO
Silver Cross Hospital & Medical Centers
Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4 day of May 2017

Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

SIGNATURE

John Krepps
PRINTED NAME

Senior VP Finance/CFO
Silver Cross Hospital & Medical Centers
Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4 day of May 2017

Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

*Insert EXACT legal name of the applicant

4821-9044-8689, v. 1

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Silver Cross Hospital & Medical Centers* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Paul Pawlak
PRINTED NAME

President & CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4 day of May 2017

Denise L. Tatgenhorst
Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

SIGNATURE

John Krepps
PRINTED NAME

Senior VP Finance/CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4 day of May 2017

Denise L. Tatgenhorst
Signature of Notary

Seal

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of USP Silver Cross, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

William H. Wilcox
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of May 2017

Rhonda L. Nicholas
Signature of Notary

Seal

RHONDA L NICHOLAS NOTARY PUBLIC STATE OF TEXAS NOTARY ID 354527-5 06/07/2020

SIGNATURE

Jason B. Cagle
PRINTED NAME

CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of May 2017

Rhonda L. Nicholas
Signature of Notary

Seal

RHONDA L NICHOLAS NOTARY PUBLIC STATE OF TEXAS NOTARY ID 354527-5 06/07/2020

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of USPI Holding Company, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

William H. Wilcox
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of May 2017

Rhonda L. Nicholas
Signature of Notary

Seal

RHONDA L NICHOLAS NOTARY PUBLIC STATE OF TEXAS NOTARY ID 354527-5 06/07/2020

SIGNATURE

Jason B. Cagle
PRINTED NAME

CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of May 2017

Rhonda L. Nicholas
Signature of Notary

Seal

RHONDA L NICHOLAS NOTARY PUBLIC STATE OF TEXAS NOTARY ID 354527-5 06/07/2020

*Insert EXACT legal name of the applicant

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.
APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. CHANGE OF OWNERSHIP (CHOW)

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(2) - A statement as to the anticipated benefits of	X

the proposed changes in ownership to the community	
1130.520(b)(2) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

Application for Change of Ownership Among Related Persons

When *a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership.* [20 ILCS 3960/8.5(a)]

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

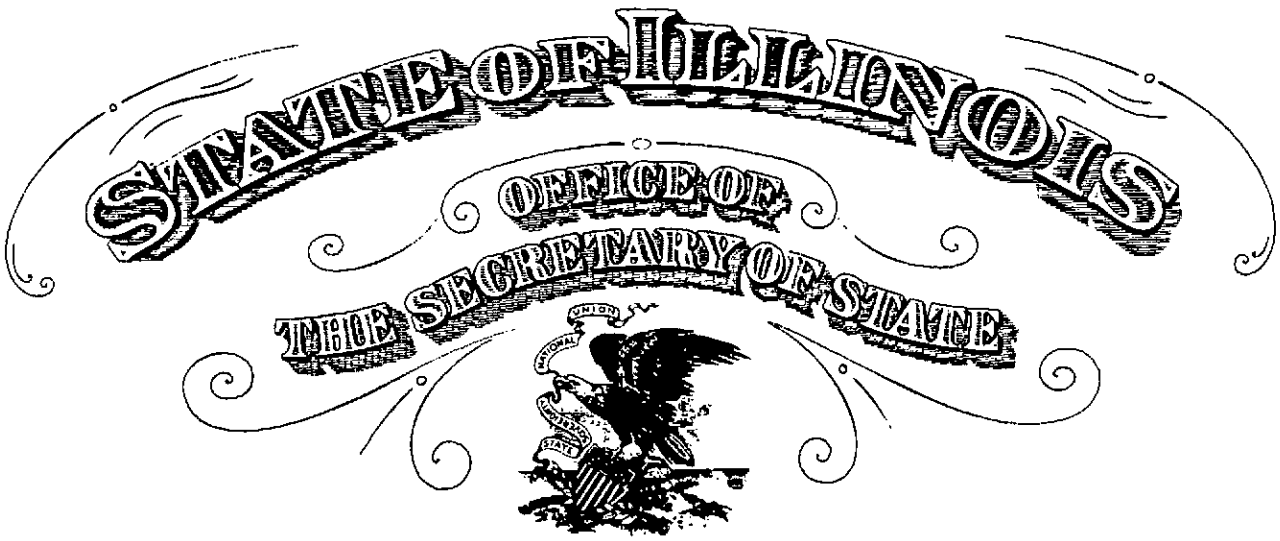
Section I
Attachment 1
Applicant Identification

The Certificates of Good Standing for Silver Cross Ambulatory Surgery Center LLC ("SCASC"), Silver Cross Hospital & Medical Centers ("Silver Cross Hospital"), USP Silver Cross, Inc. ("USP"), USPI Holding Company Inc. ("USPI"), and Silver Cross/USP Surgery Center LLC (the "Joint Venture") are attached at ATTACHMENT 1.

As set forth in the Certificate of Need Application (the "Surgery Center CON Application") filed by SCASC and Silver Cross Hospital on or about May 17, 2016, SCASC will be the license holder for the Silver Cross Ambulatory Surgery Center (the "Silver Cross Surgery Center"). See Project No. 16-021.

Following the change of ownership transaction described in this Certificate of Exemption Application, SCASC will continue to be the license holder for the Silver Cross Surgery Center.

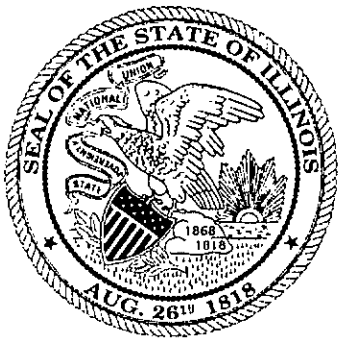
File Number 0576867-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS AMBULATORY SURGERY CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 20, 2016, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* JUNE *A.D.* 2017 .

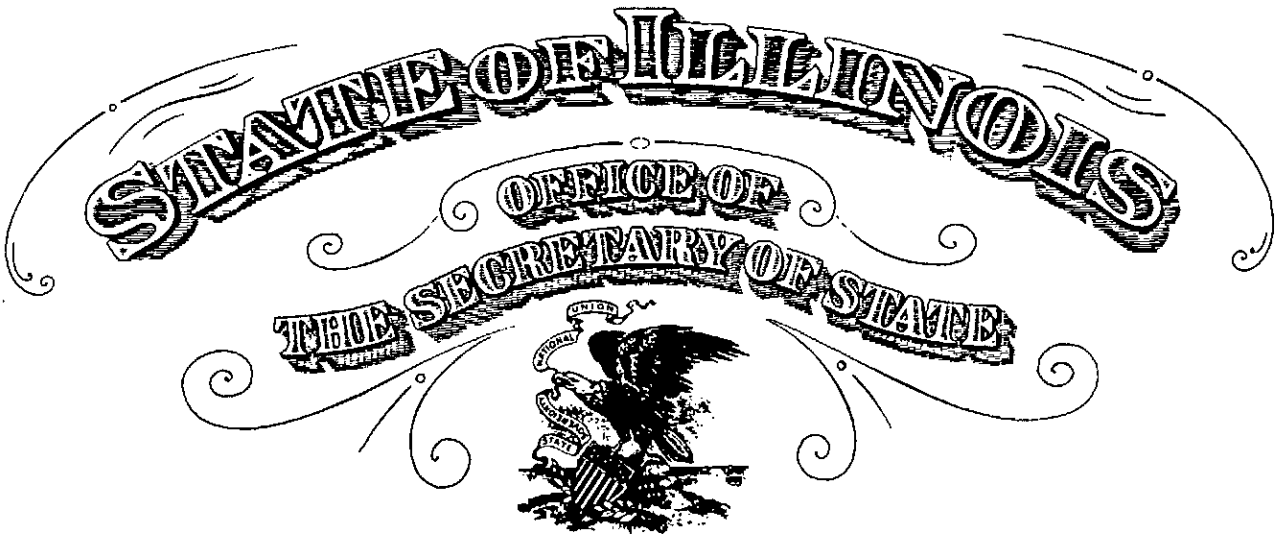
Jesse White

SECRETARY OF STATE

Authentication #: 1717401656 verifiable until 06/23/2018
Authenticate at: http://www.cyberdriveillinois.com

Attachment 1

File Number 0548-203-8



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS HOSPITAL AND MEDICAL CENTERS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 16, 1891, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

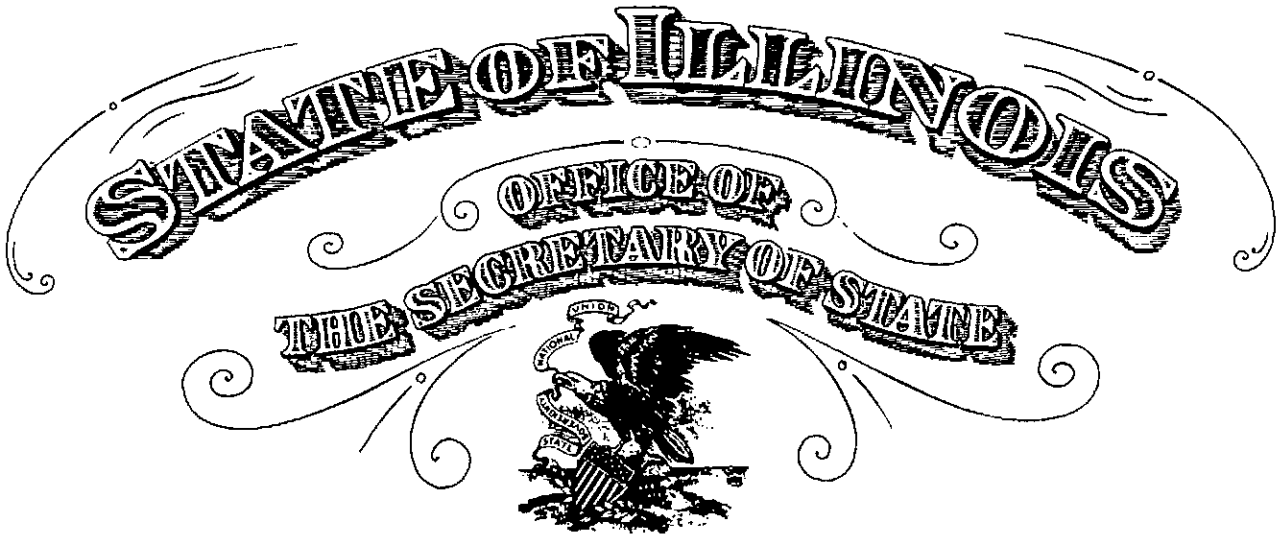
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* JUNE *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1717401678 verifiable until 06/23/2018
Authenticate at: http://www.cyberdriveillinois.com

File Number 7112-515-7



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

USP SILVER CROSS, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 10, 2017, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* JUNE *A.D.* 2017 .

Authentication #: 1717401712 verifiable until 06/23/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

File Number 0614441-1

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS/USP SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 09, 2017, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* JUNE *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1717401740 verifiable until 06/23/2018
Authenticate at: http://www.cyberdriveillinois.com

Delaware

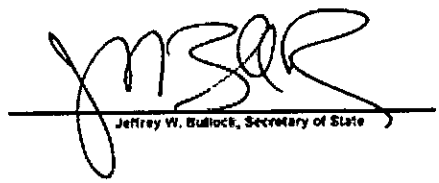
The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "USPI HOLDING COMPANY, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-THIRD DAY OF JUNE, A.D. 2017.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "USPI HOLDING COMPANY, INC." WAS INCORPORATED ON THE TWENTIETH DAY OF MARCH, A.D. 2015.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.



5714184 8300

SR# 20174917679

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 202768004

Date: 06-23-17

Attachment 1

Section I
Attachment 2
Site Ownership

Silver Cross Hospital currently owns the site parcel (the "Site Parcel") upon which the Silver Cross Surgery Center will sit. A Certification from John Krepps setting forth Silver Cross Hospital's ownership in the Site Parcel was attached at pages 27 and 28 of the Surgery Center CON Application. Following the change of ownership transaction described in this Certificate of Exemption Application, Silver Cross Hospital will continue to own the Site Parcel upon which the Silver Cross Surgery Center will sit.

Section I
Attachment 3
Operating Entity/Licensee

As set forth in the Surgery Center CON Application, SCASC will be the license holder for the Silver Cross Surgery Center. Following the change of ownership transaction described in this Certificate of Exemption Application, SCASC will continue to be the license holder for the Silver Cross Surgery Center.

The Certificate of Good Standing for SCASC is attached at ATTACHMENT 3.

File Number 0576867-5

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SILVER CROSS AMBULATORY SURGERY CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 20, 2016, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* JUNE *A.D.* 2017 .

Jesse White

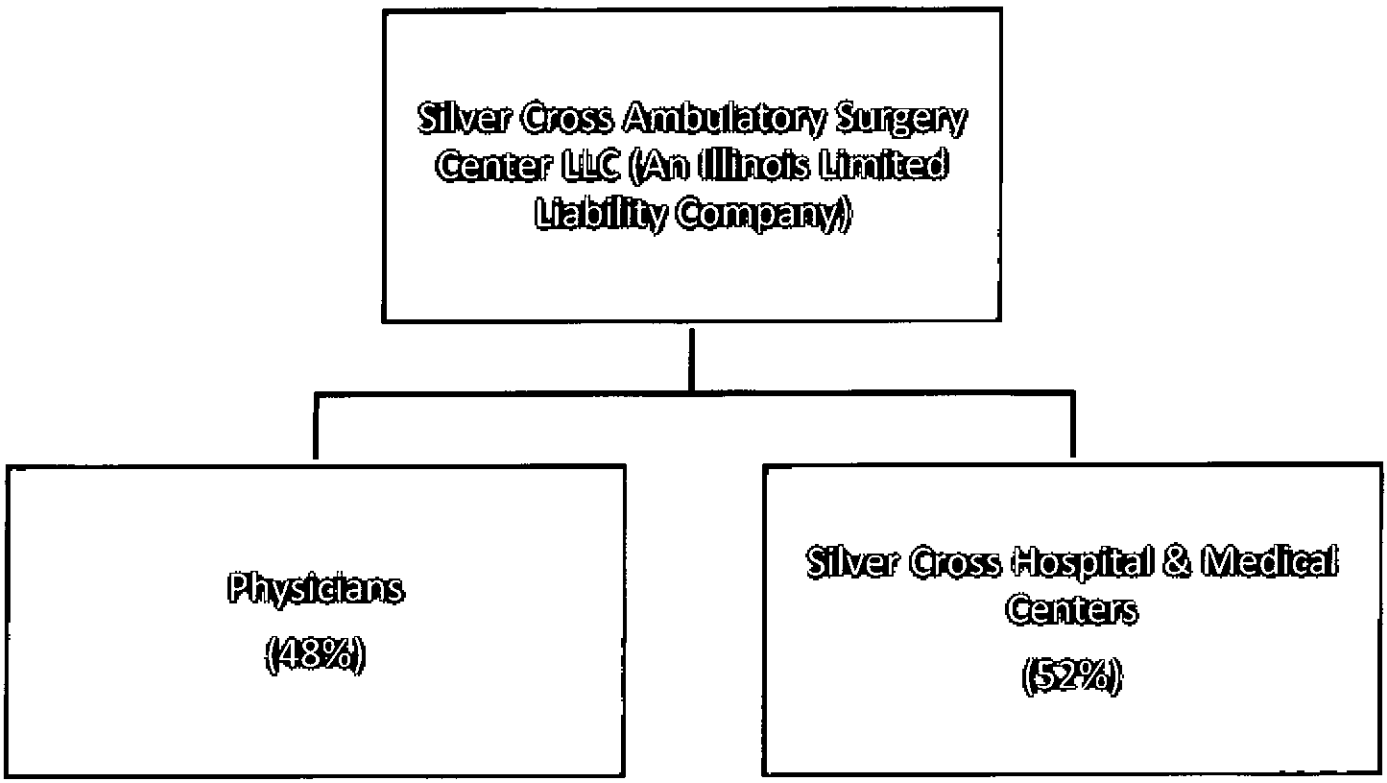
SECRETARY OF STATE

Authentication #: 1717401656 verifiable until 06/23/2018
Authenticate at: http://www.cyberdriveillinois.com

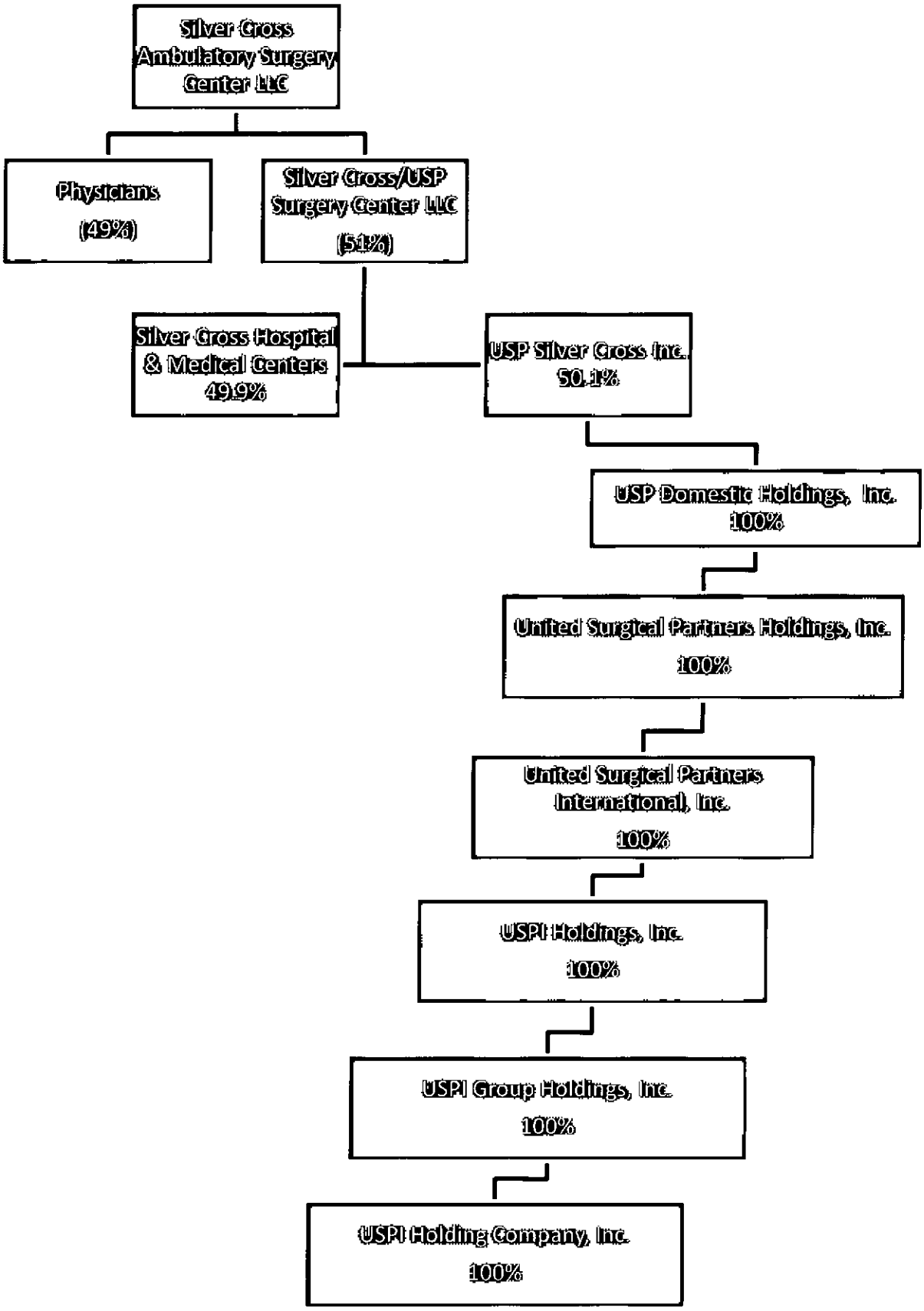
Section I
Attachment 4
Organizational Relationships

The organizational charts for the Applicants are attached at ATTACHMENT 4.

Current Structure



Post-Closing Structure



Section I
Attachment 5
Flood Plain Requirements

This Project involves a change of ownership. This Project does not involve any construction or modernization. Accordingly, this criterion is not applicable.

Section I
Attachment 6
Historic Resources Preservation Act Requirements

This Project involves a change of ownership. This Project does not involve any construction or modernization. Accordingly, this criterion is not applicable.

Section III
Attachment 11
Criterion 1110.230(a), Background of The Applicants

Silver Cross Hospital

1. Silver Cross Hospital, an Illinois not-for-profit corporation, operates a 296-bed acute care hospital in New Lenox, Illinois.

2. Silver Cross Hospital has been recognized as a Truven Health Analytics 100 Top Hospitals National Award winner for seven consecutive years, a Hospital of Choice by the American Alliance of Healthcare Providers, and was honored with an "A" Hospital Safety GradeSM by The Leapfrog Group for five consecutive periods.

3. Silver Cross Hospital has forged partnerships with several "best in breed" organizations to deliver state-of-the-art medicine on its campus in New Lenox. Those partners include the Shirley Ryan AbilityLab (formerly the Rehabilitation Institute of Chicago) on rehabilitation, Ann & Robert H. Lurie Children's Hospital of Chicago on pediatrics, University of Chicago Medicine on cancer care, and Northwestern Medicine on neurology.

4. In 2016, Silver Cross Hospital provided over $37 million in charity care and other community benefits.

5. As set forth in the attached Affidavit, Silver Cross Hospital has had no adverse actions taken against it in the last three years. See ATTACHMENT 11.

6. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about Silver Cross Hospital is attached at ATTACHMENT 11.

7. On or about May 17, 2016, Silver Cross Hospital and SCASC filed the Surgery Center CON Application with the Review Board to develop and establish the Silver Cross Surgery Center on Silver Cross Hospital's campus in New Lenox. See Project No. 16-021. On or about September 13, 2016, the Review Board approved the Surgery Center CON Application.

8. On or about February 24, 2017, Silver Cross Hospital, Silver Oaks Behavioral LLC d/b/a Silver Oaks Hospital, Silver Oaks Behavioral Realty LLC, New Lenox Behavioral Innovations LLC, New Lenox Behavioral Innovations Realty LLC, and US Healthvest LLC (collectively, the "Silver Oaks Hospital Applicants") filed a Certificate of Need Application (the "Silver Oaks Hospital CON Application") to establish a new behavioral health hospital on Silver Cross Hospital's campus in New Lenox to address the mental health crisis in Planning Area A-13. See Project No. 17-09. The Review Board is set to consider the Silver Oaks Hospital CON Application on or about June 20, 2017.

SCASC

9. SCASC, an Illinois limited liability corporation, was organized on or about April 20, 2016, by Silver Cross Hospital.

10. On or about May 17, 2016, Silver Cross Hospital and SCASC filed the Surgery Center CON Application with the Review Board to develop and establish the Silver Cross Surgery

Center on Silver Cross Hospital's campus in New Lenox. See Project No. 16-021. On or about September 13, 2016, the Review Board approved the Surgery Center CON Application.

11. On or about October 20, 2016, Silver Cross Hospital and SCASC began the process of syndicating SCASC to various physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit.

12. On or about November 20, 2016, Silver Cross Hospital and SCASC successfully syndicated SCASC, and effective as of January 1, 2017, Silver Cross Hospital sold/transferred forty seven percent (47%) of its membership interests (representing 94 membership units) in SCASC to certain physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit.

13. As set forth in the attached Affidavit, SCASC has had no adverse actions taken against it in the last three years. See ATTACHMENT 11.

14. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about SCASC is attached at ATTACHMENT 11.

USPI

15. USPI is the largest provider of ambulatory surgical care in the United States. USPI currently owns or controls 249 ambulatory surgery centers, 18 short-stay surgical hospitals, and 20 imaging centers in 29 states.

16. USPI currently serves more than 9,000 physicians and over one million patients each year. USPI maintains strategic joint-venture partnerships with more than 4,000 physicians and over 50 health systems nationwide. All of this is accomplished through a team of over 11,000 dedicated employees.

17. USPI is an experienced and trusted partner in some of the nation's most successful ambulatory surgical networks and is dedicated to providing high-quality, lower-cost solutions as various reform initiatives unfold in the communities they serve.

18. USPI partners with hospitals and health systems to further execute their ambulatory network strategies and fulfill their missions and ministries. USPI aligns with their health system partners, both clinically and economically, to enhance their facility network, while providing more access, as the importance of moving business to shorter stay settings elevates.

19. USPI has an indirect ownership interest in the following facilities in Illinois (the "USPI Illinois Facilities"):

a. 25 East Same Day Surgery Center
25 East Washington Street, Suite 300
Chicago, Illinois 60602

b. Hinsdale Surgical Center
10 Salt Creek Lane
Hinsdale, Illinois, 60521

c. North Shore Surgical Center
3725 West Touhy Avenue
Lincolnwood, Illinois 60712

d. Same Day Surgery River North
One East Erie, Suite 300
Chicago, Illinois 60611

e. Effingham Ambulatory Surgical Center
904 West Temple Street
Effingham, Illinois 62401

20. As set forth in the attached Affidavit, USPI has had no adverse actions taken against it or the USPI Illinois Facilities in the last three years. See ATTACHMENT 11.

21. An authorization letter granting access to the Review Board and IDPH to verify information about USPI is attached at ATTACHMENT 11.

22. USPI has not submitted any certificate of need applications in the past year.

USP

23. USP, an Illinois corporation, is a special purpose vehicle that was organized by USPI on or about February 10, 2017, specifically for the Transactions. Thus, USP does not currently own or operate any licensed health care facilities in Illinois.

24. USP is a wholly owned subsidiary of USPI.

The Joint Venture

26. The Joint Venture, an Illinois limited liability company, is a special purpose vehicle that was organized by USPI on or about February 9, 2017, specifically for the Transactions. Thus, the Joint Venture does not currently own or operate any licensed health care facilities in Illinois.

27. Following the consummation of the Transactions, USP will own 50.1% of the Joint Venture and Silver Cross will own 49.9% of the Joint Venture.

28. Following the consummation of the Transactions, the Joint Venture will own 51% of SCASC.

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

May 1, 2017

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.230, No Adverse Action Certification

Dear Mr. Constantino:

Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby certify that there have been no adverse actions taken against any facility owned or operated by Silver Cross Ambulatory Surgery Center LLC or Silver Cross Hospital and Medical Centers during the three (3) years prior to the filing of this application.

Sincerely,

Paul Pawlak
President & CEO
Silver Cross Ambulatory Surgery Center LLC
Silver Cross Hospital and Medical Centers

Subscribed and Sworn to before me
this 4 day of May, 2017.

Denise L. Tatgenhorst
Notary Public

4816-5305-3489, v. 1

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Attachment
11

SILVER CROSS HOSPITAL

1900 Silver Cross Blvd. • New Lenox, IL 60451
(815) 300-1100 • www.silvercross.org

May 1, 2017

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.230, Authorization to Access Information

Dear Mr. Constantino:

Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Silver Cross Ambulatory Surgery Center LLC and Silver Cross Hospital and Medical Centers with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

Paul Pawlak
President & CEO
Silver Cross Ambulatory Surgery Center LLC
Silver Cross Hospital and Medical Centers

Subscribed and Sworn to before me
this 4 day of May, 2017.

Denise L. Tatgenhorst
Notary Public

4816-3666-9489, v. 1

DENISE L TATGENHORST
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
August 15, 2018

Attachment
11

United Surgical Partners
INTERNATIONAL

May 25, 2017

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.230, No Adverse Action Certification

Dear Mr. Constantino:

Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby certify that there have been no adverse actions taken against any facility owned or operated in Illinois by USPI Holding Company, Inc., USPI Group Holdings, Inc., USPI Holdings, Inc., United Surgical Partners International, Inc., United Surgical Partners Holdings, Inc., USP Domestic Holdings, Inc., and/or USP Silver Cross, Inc., during the three (3) years prior to the filing of this application.

Sincerely,

William H. Wilcox
Chief Executive Officer, USPI Holding Company, Inc.
Chief Executive Officer, USPI Group Holdings, Inc.
Chief Executive Officer, USPI Holdings, Inc.
Chief Executive Officer, United Surgical Partners International, Inc.
President, United Surgical Partners Holdings, Inc.
President, USP Domestic Holdings, Inc.
President, USP Silver Cross, Inc.

Subscribed and Sworn to before me
this 25 day of May, 2017.

Rhonda L. Nicholas
Notary Public

RHONDA L NICHOLAS
NOTARY PUBLIC
STATE OF TEXAS
NOTARY ID 354527-5
06/07/2020

4845-0443-1943, v. 2

United Surgical Partners
INTERNATIONAL

May 25, 2017

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Criterion 1110.230, Authorization to Access Information

Dear Mr. Constantino:

Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by USPI Holding Company, Inc., USPI Group Holdings, Inc., USPI Holdings, Inc., United Surgical Partners International, Inc., United Surgical Partners Holdings, Inc., USP Domestic Holdings, Inc., and/or USP Silver Cross, Inc., with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

William H. Wilcox
Chief Executive Officer, USPI Holding Company, Inc.
Chief Executive Officer, USPI Group Holdings, Inc.
Chief Executive Officer, USPI Holdings, Inc.
Chief Executive Officer, United Surgical Partners International, Inc.
President, United Surgical Partners Holdings, Inc.
President, USP Domestic Holdings, Inc.
President, USP Silver Cross, Inc.

Subscribed and Sworn to before me
this 25 day of May, 2017.

Notary Public

RHONDA L NICHOLAS
NOTARY PUBLIC
STATE OF TEXAS
NOTARY ID 354527-5
06/07/2020

4847-7050-8103, v. 2

Section V
Attachment 15
Criterion 1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

Criterion 1130.520(b)(1)(A), Name of the Parties

1. See Criterion 1110.230(a), Background of The Applicants, in support of this Criterion.

Criterion 1130.520(b)(1)(B), Background of the Applicants

1. See Criterion 1110.230(a), Background of The Applicants, in support of this Criterion.

Criterion 1130.520(b)(1)(C), Structure of the Transaction

1. On or about March 31, 2017, Silver Cross Hospital and USP entered into that certain Contribution Agreement (the "Contribution Agreement") pursuant to which: (a) Silver Cross Hospital agreed to transfer and contribute 102 membership units in SCASC to the Joint Venture (the "Transferred Interest"), pursuant to the terms and conditions set forth in the Contribution Agreement; and (b) USP agreed to transfer and contribute One Million, One Hundred Twenty Four Thousand, Two Hundred Forty Four Dollars ($1,124,244) (which represents a per unit price of $22,000) to the Joint Venture, which amount will, in turn, be paid to Silver Cross Hospital in consideration for Silver Cross Hospital's transfer of the Transferred Interest to the Joint Venture, pursuant to the terms and conditions set forth in the Contribution Agreement. The Contribution Agreement also contemplates that Silver Cross Hospital will sell an additional 2 membership units in SCASC to the Physician Members (or another physician on the medical staff at Silver Cross Hospital) prior to the closing of the Transactions, as contemplated by the Management Agreement and the Contribution Agreement.

2. USP (via USPI) will be funding its acquisition with cash. A copy of USPI's financial statements are attached as ATTACHMENT 15.

3. See Narrative in further support of this Criterion.

Criterion 1130.520(b)(1)(D), Licensed Party

1. As set forth in the Surgery Center CON Application, SCASC will be the license holder for the Silver Cross Surgery Center. Following the change of ownership transaction described in this Certificate of Exemption Application, SCASC will continue to be the license holder for the Silver Cross Surgery Center.

Criterion 1130.520(b)(1)(E), List of Ownership Interests in the Licensed Party

1. SCASC currently owns 100% of the Silver Cross Surgery Center. The Transactions will not alter that ownership interest.

2. Physician Members currently own 48% of SCASC and Silver Cross Hospital owns 52% of SCASC.

3. Following the closing of the Transactions, Physician Members will own 49% of SCASC and the Joint Venture will own 51% of SCASC. And USP will own 50.1% of the Joint Venture

and Silver Cross Hospital will own 49.9% of the Joint Venture – which, means Silver Cross Hospital will indirectly own 25.45% of SCASC (by virtue of its ownership interest in the Joint Venture) and USP will indirectly own 25.55% of SCASC (by virtue of its ownership interest in the Joint Venture).

Criterion 1130.520(b)(1)(F), Fair Market Value of Equity Being Transferred

1. On or about November 20, 2016, Silver Cross Hospital and SCASC successfully syndicated SCASC, and effective as of January 1, 2017, Silver Cross Hospital sold/transferred forty seven percent (47%) of its membership interests (representing 94 membership units) in SCASC to certain physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit.

2. On or about March 10, 2017, Silver Cross Hospital and SCASC sold/transferred an additional one percent (1%) of its membership interests (representing 2 membership interests) in SCASC to certain physicians on the medical staff at Silver Cross Hospital at a sale/transfer price of Twenty Two Thousand Dollars ($22,000) per unit.

3. Thus, the fair market value of a single unit in SCASC is Twenty Two Thousand Dollars ($22,000).

Criterion 1130.520(b)(1)(G), Purchase Price of the Equity Being Transferred

1. Under the Transactions, USP is paying Twenty Two Thousand Dollars ($22,000) for a single unit of SCASC – which is equal to the fair market value of a single unit of SCASC.

Criterion 1130.520(b)(2), Completion of Pending CONs

1. On or about May 17, 2016, Silver Cross Hospital and SCASC filed the Surgery Center CON Application with the Review Board to develop and establish the Silver Cross Surgery Center on Silver Cross Hospital's campus in New Lenox. See Project No. 16-021. On or about September 13, 2016, the Review Board approved the Surgery Center CON Application.

2. The Surgery Center CON listed a project completion date of March 31, 2018, for the Silver Cross Surgery Center. Silver Cross Hospital and SCASC are currently anticipating a project completion date well in advance of March 31, 2018.

3. The Transactions set forth in this Certificate of Exemption shall not have any impact on the Silver Cross Surgery Center CON.

Criterion 1130.520(b)(3), Charity Care Policies

1. The change of ownership contemplated by this Certificate of Exemption does not involve a hospital. Accordingly, this Criterion is not applicable.

Criterion 1130.520(b)(4), Benefits to the Community

1. The Transactions will satisfy the desire of Silver Cross Hospital to secure superior management services for the Silver Cross Surgery Center. Indeed, just like Silver Cross Hospital's partnerships with Shirley Ryan AbilityLab (formerly the Rehabilitation Institute of Chicago) on rehabilitation, Ann & Robert H. Lurie Children's Hospital of Chicago on pediatrics,

University of Chicago Medicine on cancer care, and Northwestern Medicine on neurology, USPI represents the "best in breed" when it comes surgery center management in the United States. In other words, the Silver Cross Surgery Center (and the Community served by the Silver Cross Surgery Center) will benefit tremendously from the presence of USPI at the Silver Cross Surgery Center.

Criterion 1130.520(b)(5), Cost Savings

1. Given the structure of the Transactions, the Silver Cross Surgery Center will be able to take advantage of USPI's national vendor purchasing agreements and national equipment purchasing agreements; which will result in significant operational savings to the Silver Cross Surgery Center. USPI also has a number of proprietary surgery center management tools that will allow the Silver Cross Surgery Center to increase its operational efficiency and reduce its costs.

Criterion 1130.520(b)(6), Quality Improvement

1. USPI's most important operational tool is its "Every Day Giving Excellence," referred to as USPI's EDGE™. This proprietary measurement system allows USPI to track their clinical, service and financial performance, best practices and key indicators in each of their facilities. The goal is to use USPI's EDGE™ to ensure the facility provides each of patient with high quality healthcare, offers physicians a superior work environment and eliminates inefficiencies.

2. Using USPI's EDGE™, USPI is able to track and monitor performance in areas such as: (1) providing surgeons the equipment, supplies and surgical support they need; (2) starting cases on time; (3) minimizing turnover time between cases; and (4) providing efficient case and personnel schedules. USPI's EDGE™ compiles and organizes the specified information on a daily basis and is easily accessed over the Internet by facilities on a secure basis. The information provided by USPI's EDGE™ enables employees, facility administrators and management to analyze trends over time and share processes and best practices among facilities. In addition, this valuable information is used as an evaluative tool by administrators and as a budgeting and planning tool by management.

3. All of the USPI surgical facilities are accredited by either the Joint Commission or by the Accreditation Association for Ambulatory Healthcare. USPI's historical performance in the accreditation process reflects its commitment to providing high quality care in all of its surgical facilities. The Silver Cross Surgery Center will be accredited by the Joint Commission

Criterion 1130.520(b)(7), Governing Body

1. Following the Transactions, SCASC (which owns the Silver Cross Surgery Center) will be governed by a Board of Managers. Silver Cross Hospital will have 2 seats, USPI will have 2 seats, and the Physician Members will have 3 seats, on the SCASC Board of Managers. The Physician Members have already elected their 3 Managers for the Board of Managers.

2. Following the Transactions, the Silver Cross Surgery Center will also have a Medical Executive Committee comprised of Physician Members.

Criterion 1130.520(b)(8), Section 1110.240 Written Response

1. The Applicants have addressed the review criteria set forth in 77 Ill. Admin. Code § 1110.240, a copy of which is available for public review at Silver Cross Hospital.

Criterion 1130.520(b)(9), Scope of Service Changes or Charity Care Changes

1. The Transactions set forth in this Certificate of Exemption will result in no changes to the scope of services offered at the Silver Cross Surgery Center. The Transactions set forth in this Certificate of Exemption will result in no changes to the charity care policies for the Silver Cross Surgery Center.

UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

For the Fiscal Year Ended December 31, 2014

Commission file No. 333-144337

UNITED SURGICAL PARTNERS INTERNATIONAL, INC.

(Exact name of Registrant as specified in its charter)

Delaware	**75-2749762**
(State of Incorporation)	*(I.R.S. Employer Identification No.)*
15305 Dallas Parkwey, Suite 1600 **Addison, Texas** *(Address of principal executive offices)*	**75001** *(Zip Code)*

(972) 713-3500
(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act:
None

Securities Registered Pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☑

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☑ No ☐

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☐	Non-accelerated filer ☑ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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

None of the registrant's common stock is held by non-affiliates.

As of February 25, 2015, 100 shares of the Registrant's common stock were outstanding.

Documents Incorporated by Reference
None.

Attachment
15

UNITED SURGICAL PARTNERS INTERNATIONAL, INC.

2014 ANNUAL REPORT ON FORM 10-K

TABLE OF CONTENTS

FORWARD LOOKING STATEMENTS

Certain statements contained in this Annual Report on Form 10-K, including, without limitation, statements containing the words "believes," "anticipates," "expects," "continues," "will," "may," "should," "estimates," "intends," "plans" and similar expressions, and statements regarding the Company's business strategy and plans, constitute "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Such forward-looking statements are based on management's current expectations and involve known and unknown risks, uncertainties and other factors, many of which the Company is unable to predict or control, that may cause the Company's actual results, performance or achievements to be materially different from those expressed or implied by such forward-looking statements. Such factors include, among others, the following: our significant indebtedness; general economic and business conditions, including without limitation the condition of the financial markets; demographic changes; changes in, or the failure to comply with, laws and governmental regulations and guidance; the ability to enter into or renew reimbursement arrangements on acceptable terms; changes in Medicare, Medicaid and other government funded payments or reimbursement; changes in our payor mix or case mix; the efforts of insurers, employers and others to contain healthcare costs; healthcare reform; liability and other claims asserted against us; shortages of or quality control issues with medical supplies and equipment; the highly competitive nature of healthcare; changes in business strategy or development plans of healthcare systems with which we partner; the ability to attract and retain qualified physicians and personnel, including nurses, other healthcare professionals and other personnel; the availability of suitable acquisition and development opportunities and the length of time it takes to complete acquisitions and developments; our ability to integrate new and acquired businesses with our existing operations; the availability and terms of capital to fund the expansion of our business and certain additional factors, risks and uncertainties discussed in this Annual Report on Form 10-K. We disclaim any obligation and make no promise to update any such factors or forward-looking statements or to publicly announce the results of any revisions to any such factors or forward-looking statements, whether as a result of changes in underlying factors, to reflect new information as a result of the occurrence of events or developments or otherwise. Given these uncertainties, investors and prospective investors are cautioned not to rely on such forward-looking statements.

PART I

Item 1. *Business*

General

United Surgical Partners International, Inc. (together with its subsidiaries, the "Company" or "USPI", unless otherwise indicated or the context otherwise requires, the terms "we," "us," "our" and similar terms refer to USPI and its subsidiaries) owns and operates short-stay surgical facilities which are licensed as either ambulatory surgery centers, specialty hospitals or hospitals. We provide strategic solutions for physicians, physician networks, leading health systems and those paying for the cost of healthcare services, such as employers, insurance companies and government programs. Our strategy enables our partners and other aligned constituents to benefit from the high-quality, lower-cost settings in our facilities under financial structures that work for them. Our partner relationships often expand into new ventures and a stronger market presence which enhances our growth prospects and strategic position within a market. We focus primarily on providing high quality surgical facilities that meet the needs of patients, physicians and payors better than hospital-based and other outpatient surgical facilities. We believe that our facilities (1) enhance the quality of care and the healthcare experience of patients, (2) offer a strategic approach for physicians that provides significant administrative, clinical and economic benefits to physicians, (3) offer a strategic approach for our health system partners to expand capacity and access within the markets they serve, and (4) offer an efficient and low cost alternative for payors, employers and other financing organizations. We acquire and develop our facilities through the formation of strategic relationships with physicians and health system partners to better access and serve the communities in our markets. Our operating model is efficient and scalable, and we have adapted it to each of our markets. We believe that our acquisition and development strategy and operating model enable us to continue to grow by taking advantage of highly-fragmented markets, an increasing demand for short-stay surgery and a need by both our health system partners and physician partners to facilitate strategic networks to meet the needs of the evolving healthcare landscape. We are dedicated to providing high-quality, lower-cost solutions as various reform initiatives unfold in the communities we serve. We provide strategic solutions for physicians, health systems and those paying the cost of healthcare services such as employers, insurance companies and government programs.

We have developed our operating model to encourage physicians to affiliate with us and to use our facilities as an extension of their practices. We believe our physicians align with us in part to solidify their market position as networks form and narrow, to increase their productivity, to better control the outcomes of the facilities in which they practice and to ensure excellence in the experience of their patients and families. We operate our facilities, structure our strategic relationships and adopt staffing, scheduling and clinical systems and protocols with the goal of increasing physician productivity. We believe that our focus on physician satisfaction, combined with providing high quality healthcare in a friendly and convenient environment for patients, will continue to increase the number of procedures performed at our facilities each year.

Health systems partner with us to plan, develop and execute their diversification strategies and expand their ambulatory footprint. We align with our health system partners both clinically and economically to enhance their network, while providing more access, as the importance of moving business to shorter stay settings escalates.

As of December 31, 2014, we operated 219 short-stay surgical facilities in 27 states. Of the 219 facilities, 154 are jointly owned with major health system partners. Due in large part to our partnerships with physicians and health system partners, we do not consolidate the financial results of 156 of the 219 facilities in which we have ownership, meaning that while we record a share of their net profit within our operating income, we do not include their revenues and expenses in the consolidated revenue and expense line items of our consolidated financial statements. Until April 3, 2012, we also had ownership in seven facilities in the United Kingdom. On April 3, 2012, we distributed the stock of our U.K. subsidiary to our parent's (USPI Group Holdings, Inc.) equity holders. Subsequent to April 3, 2012, we have had no further ownership in the U.K. operations.

Our consolidated revenues increased 4% from $616.2 million in 2013 to $640.8 million in 2014. In addition to our consolidated revenues, we also review an internal operating measure called systemwide revenue growth, which includes both consolidated and unconsolidated facilities. Our systemwide revenues grew 8% during 2014. While revenues of our unconsolidated facilities are not recorded as revenues by USPI, we believe the information is important in understanding USPI's financial performance 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 USPI's equity in earnings of unconsolidated affiliates. In addition, we disclose growth rates and operating margins for the facilities that were operational in both the current and prior year periods, a group we refer to as same-store facilities.

Donald E. Steen formed USPI with the private equity firm Welsh, Carson, Anderson & Stowe in February 1998 and had publicly traded equity securities from June 2001 until April 2007. Pursuant to an Agreement and Plan of Merger (the merger) dated as of January 7, 2007, with an affiliate of Welsh, Carson, Anderson & Stowe X, L.P. ("Welsh Carson"), we became a wholly owned subsidiary of USPI Holdings, Inc. on April 19, 2007. USPI Holdings, Inc. is a wholly owned subsidiary of USPI Group Holdings, Inc., which is owned by an investor group that includes affiliates of Welsh Carson, members of our management and other investors. As a result of the merger, we no longer have publicly traded equity securities.

Available Information

We file annual, quarterly and current reports with the Securities and Exchange Commission (SEC). You may read and copy any document that we file at the SEC's public reference room located at 100 F Street, N.E., Washington, D.C. 20549. You may also call the SEC at 1-800-SEC-0330 for information on the operation of the public reference room. Our SEC filings are also available to you free of charge at the SEC's web site at *http://www.sec.gov*. We also maintain a web site at *http://www.uspi.com* that includes links to our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and any amendments to those reports. These reports are available on our website without charge as soon as reasonably practicable after such reports are filed with or furnished to the SEC. Information on our web site is not deemed incorporated by reference into this Form 10-K.

Industry Overview

Each year, the United States spends a substantial amount of funds on medical costs. According to reports from the Centers for Medicare and Medicaid Services ("CMS"), the United States spent $2.9 trillion on healthcare in 2013, and the percentage of gross domestic product devoted to healthcare has increased from 7.2% in 1970 to 17.4% in 2013.

We believe many physicians and patients prefer surgery centers and surgical hospitals over general acute care hospitals. We believe that this is due to the non-emergency nature of the procedures performed at our facilities, which allows physicians to schedule their time more efficiently and therefore increase the number of surgeries they can perform in a given amount of time. In addition, outpatient facilities usually provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases. While surgery centers and surgical hospitals generally perform scheduled surgeries, large acute care hospitals generally provide a broad range of services, including high priority and emergency procedures. Medical emergencies often demand the unplanned use of operating rooms and result in the postponement or delay of scheduled surgeries, disrupting physicians' practices and inconveniencing patients. Surgery centers and surgical hospitals are designed to improve physician work environments and improve physician efficiency. In addition, many physicians choose to perform surgery in facilities like ours because their patients prefer the comfort of a less institutional atmosphere and the convenience of simplified admissions and discharge procedures.

New surgical techniques and technology, as well as advances in anesthesia, have significantly expanded the types of surgical procedures that are being performed in surgery centers and have helped drive the growth in

outpatient surgery. Improved anesthesia has shortened recovery time by minimizing post-operative side effects such as nausea and drowsiness, thereby avoiding the need for overnight hospitalization in many cases. In addition, some states in the United States permit surgery centers to keep a patient for up to 23 hours. This allows more complex surgeries, previously only performed in an inpatient setting, to be performed in a surgery center.

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

Today, large healthcare systems generally offer both inpatient and outpatient surgery on site. In connection with the implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, or the Acts, the associated healthcare reform activities and the expected transition to more connected, value-based care management models, there is a rise in consolidation activities within the industry with certain payors expanding into the provider space along with an increase in hospital mergers and acquisitions. In addition, a number of healthcare systems have begun to expand their portfolios of facilities and services by entering into strategic relationships with specialty operators of surgery centers in order to expand capacity and access in the markets they serve. These strategic relationships enable healthcare systems to offer patients, physicians and payors the cost advantages, convenience and other benefits of outpatient surgery in a freestanding facility and, and in certain markets, establish networks needed to manage the full continuum of care for a defined population. Further, these relationships allow the healthcare systems to focus their attention and resources on their core business without the challenge of acquiring, developing and operating these facilities.

Our Business Strategy

Our goal is to steadily increase our revenues and cash flows. The key elements of our business strategy are to:

- attract, retain and pursue strategic relationships with top quality surgeons and other physicians;
- expand our presence in existing markets and assist with the development of integrated networks in certain markets;
- pursue strategic relationships with leading health system partners;
- expand selectively in new markets; and
- enhance operating efficiencies and the healthcare experience of patients.

Attract and retain top quality surgeons and other physicians

We have developed our operating model to encourage physicians to affiliate with us and to use our facilities as an extension of their practices. We believe we attract physicians because we design our facilities, structure our strategic partnerships and adopt marketing and sales, staffing, scheduling and clinical systems and protocols to increase physician productivity and promote their professional and financial success both at our facilities and in the physicians' practices. We believe this focus on physicians, combined with providing safe, high quality healthcare in a friendly and convenient environment for patients, will continue to increase case volumes at our

facilities. In addition, we generally offer physicians the opportunity to purchase equity interests in the facilities they use as an extension of their practices and to actively participate in the management of their facilities, through service on the facilities' governing boards, medical executive committees and partnership advisory boards. We believe the opportunity for physicians to own and actively participate in the management of our facilities attracts quality physicians and increases physicians' commitment to facility operations, enhances quality of patient care, increases productivity, reduces costs and promotes enduring partnerships.

Expand our presence in existing markets

One of the key elements of our business strategy is to grow selectively in markets in which we already operate facilities. We believe that selective acquisitions and development of new facilities in existing markets allow us to leverage our existing knowledge of these markets and to improve operating efficiencies. In particular, our experience has been that newly developed facilities in markets where we already have a presence and a health system partner is one of the best uses of our capital. In addition, in certain markets, we believe that we can leverage the infrastructure in place to assist our strategic partners with the development of integrated networks needed to meet the needs of the evolving healthcare landscape.

Pursue strategic relationships with health system partners.

Through strategic relationships with us, health systems can benefit from our operating expertise, create a new cash flow opportunity with limited capital expenditures and develop the ambulatory components of a network needed for patient retention and care management across the continuum. We believe that these relationships also allow health systems to attract and retain physicians and secure alignment needed for new delivery system objectives, create new access points to support their missions or ministries, and improve their hospital operations by focusing on their core business. We also believe that strategic relationships with these healthcare systems help us to more quickly develop relationships with physicians, communities, payors, employers and other financing organizations. Generally, the healthcare systems with which we develop relationships have strong local market positions and excellent reputations that we use in branding our facilities. In addition, our relationships with health system partners enhance our acquisition and development efforts by (1) providing opportunities to acquire facilities the systems may own, (2) providing access to physicians already affiliated with the systems, (3) attracting additional physicians to affiliate with newly developed facilities, and (4) encouraging physicians who own facilities to consider a strategic relationship with us.

Expand selectively in new markets

We may continue to enter targeted markets by acquiring and developing surgical facilities. We expect we will often undertake these activities in conjunction with a local health system partner. We typically target the acquisition or development of multi-specialty centers that perform high volume, non-emergency, lower risk procedures requiring lower capital and operating costs than hospitals. In addition, we will also consider the acquisition of multi-facility companies.

In determining whether to enter a new market, we examine numerous criteria, including:

- the potential to achieve strong increases in revenues and cash flows;
- whether the physicians, healthcare systems and payors in the market are receptive to surgery centers and/or surgical hospitals;
- the demographics of the market;
- the number of surgical facilities in the market;
- the number and nature of outpatient surgical procedures performed in the market;

- the case mix of the facilities to be acquired or developed;
- whether the facility is or will be well-positioned to negotiate agreements with insurers and other payors; and
- licensing and other regulatory considerations.

Upon identifying a target facility, we conduct clinical, financial, legal and compliance, operational, technology and systems reviews of the facility and conduct interviews with the facility's management, affiliated physicians and staff. Once we acquire or develop a facility, we focus on implementing our proprietary systems and protocols, USPI's EDGE, to increase case volume and improve operating efficiencies.

Enhance operating efficiencies and the healthcare experience of patients

Once we acquire a new facility, we integrate it into our existing network by implementing a specific action plan to support the local management team, design growth strategies and incorporate the new facility into our group purchasing contracts. We also implement our systems and protocols to improve operating efficiencies and contain costs by optimizing materials management and billing and collection practices. Our most important operational tool is our management system "Every Day Giving Excellence," which we refer to as USPI's EDGE. This proprietary process management and measurement system allows us to track our clinical, service and financial performance, best practices and key indicators in each of our facilities. Our goal is to use USPI's EDGE to ensure that we provide each of the patients using our facilities with high quality healthcare, offer physicians a superior work environment and eliminate inefficiencies. Using USPI's EDGE, we track and monitor our performance in areas such as (1) providing surgeons the equipment, supplies and surgical support they need, (2) starting cases on time, (3) minimizing turnover time between cases, and (4) providing efficient case and personnel schedules. USPI's EDGE compiles and organizes the specified information on a daily basis and is easily accessed over the Internet by our facilities on a secure basis. The information provided by USPI's EDGE enables our medical staffs, employees, facility administrators and management to analyze trends over time and share processes and best practices among our facilities. USPI's EDGE is now deployed in substantially all of our facilities. In addition to continuing to invest in USPI's EDGE, we have also invested in decision support, market analysis and training tools that will allow us to better manage our facilities. We have installed an EHR system at all of our hospitals, and we are leveraging this experience to assess the need and timing of developing an electronic health record solution for our surgery centers.

Operations

We are an experienced and trusted partner in some of the nation's most successful surgical networks. We provide strategic solutions for physicians, physician networks, leading health systems and those paying for the cost of healthcare services, such as employers, insurance companies and government programs.

Our operations consist primarily of our ownership and management of surgery centers. As of December 31, 2014, we had ownership interests in 203 surgery centers and 16 surgical hospitals. We also have numerous other potential projects in various stages of consideration, which may result in our adding additional facilities during 2015. Approximately 11,000 physicians have privileges to use our facilities. Our surgery centers are licensed outpatient surgery centers, and our surgical hospitals are licensed as hospitals. Each of our facilities is generally equipped and staffed for multiple surgical specialties and located in freestanding buildings or medical office buildings. Our average surgery center has approximately 12,000 square feet of space with three operating rooms, as well as ancillary areas for preparation, recovery, reception and administration. Our surgery center facilities range from a 2,000 square foot, one operating room facility to a 33,000 square foot, nine operating room facility. Our surgery centers are normally open weekdays from 7:00 a.m. to approximately 5:00 p.m. or until the last patient is discharged. We estimate that a surgery center with three operating rooms can accommodate up to 4,500 procedures per year. Our surgical hospitals have from six to 68 beds and average approximately 65,000 square feet of space with eight operating rooms, ranging in size from 30,000 to 177,000 square feet and having from five to seventeen operating rooms.

Our surgery center support staff typically consists of registered nurses, operating room technicians, an administrator who supervises the overall activities and strategies of the surgery center, and a small number of office staff. Each center also has appointed a medical director, who is responsible for supervising the quality of medical care provided at the center. Use of our surgery centers is generally limited to licensed physicians, podiatrists and oral surgeons who are also on the medical staff of a local accredited hospital. Each center maintains a peer review committee consisting of physicians who use our facilities and who review the professional credentials of physicians applying for surgical privileges. Our surgery centers generally have service agreements with anesthesiologists and certified registered nurse anesthetists (CRNAs) to provide anesthesiology services.

Substantially all of our surgical facilities are accredited by either The Joint Commission on Accreditation of Healthcare Organizations or by the Accreditation Association for Ambulatory Healthcare. From time to time, a few of our surgical facilities are in the process of applying for such accreditation. We believe that accreditation is the quality benchmark for managed care organizations. Many managed care organizations will not contract with a facility until it is accredited. We believe that our historical performance in the accreditation process reflects our commitment to providing high quality care in our surgical facilities.

Generally, our surgical facilities are limited partnerships, limited liability partnerships or limited liability companies in which ownership interests are also held by local physicians who are on the medical staff of the facilities. Our ownership interests in the facilities range from 5% to 95%, with our average ownership being approximately 34%. Our partnership and limited liability company agreements typically provide for the monthly or quarterly pro rata distribution of cash equal to net profits from operations, less amounts held in reserve for expenses and working capital. Our facilities derive their operating cash flow by collecting a fee from patients, insurance companies, or other payors in exchange for providing the facility and related services a surgeon requires in order to perform a surgical case. Our billing systems estimate revenue and generate contractual adjustments based on a fee schedule for approximately 90% of the total cases performed at our facilities. For the remaining cases, the contractual allowance is estimated based on the historical collection percentages of each facility by payor group. The historical collection percentage is updated quarterly for each facility. We estimate each patient's financial obligation prior to the date of service. We request payment of that obligation at the time of service. Any amounts not collected at the time of service are subject to our normal collection and reserve policy. We also have a management agreement with each of the facilities under which we provide day-to-day management services for a management fee that is typically a percentage of the net revenues of the facility.

Our business depends upon the efforts and success of the physicians who provide medical services at our facilities and the strength of our relationships with these physicians. Our business could be adversely affected by the loss of our relationship with, or a reduction in use of our facilities by, a key physician or group of physicians. The physicians that affiliate with us and use our facilities are not our employees, except in a limited number of circumstances. However, we generally offer the physicians the opportunity to purchase equity interests in the facilities they use.

Strategic Relationships

A key element of our business strategy is to pursue strategic relationships with health system partners in selected markets. Of our 219 facilities, 154 are jointly-owned with health system partners. Our strategy involves developing these relationships in three primary ways. One way is by adding new facilities in existing markets with our existing health system partners. An example of this is our relationship with Baylor Scott & White Health, which is the new nonprofit healthcare system created from the affiliation agreement entered into by Baylor Health Care System and Scott & White Healthcare effective October 1, 2013. Our joint ventures with Baylor Scott & White Health own a network of 33 surgical facilities that serve the approximately six and one-half million people in the Dallas / Fort Worth area. Another example of a growing single-market relationship is our network of facilities in Houston, Texas with Memorial Hermann Healthcare System, with whom we opened our first facility in 2003 and with whom we now operate 21 facilities.

A second way we develop these relationships is through expansion into new markets, both with existing health system partners and with new partners. In 2014, we entered into a new health system partner relationship with Mercy Health in St. Louis, Missouri and Trinity Health in South Dakota. In 2013, we entered into a new health system partner relationship with Orlando Health in Orlando, Florida and St. Mary's Good Samaritan in Illinois. During 2012, we entered into new health system partner relationships in Midland, Texas; Hackensack, New Jersey and also gained two new health system partners in Pennsylvania. A good long-term example of this strategy is our relationship with Ascension Health, with whom we initially owned a single facility in Nashville, Tennessee and now have a total of 22 facilities in four states. Similarly, with Dignity Health we began with one facility, which was in a suburb of Las Vegas, Nevada. This relationship has expanded to a total of 19 facilities, including eight in various California markets, nine in the Phoenix, Arizona market and two in the Las Vegas area.

A third way we develop our strategic relationships with health system partners is by adding them as co-owners of facilities that we have previously operated without them as partners. During 2013, we completed two transactions of this nature by expanding our joint ventures with Memorial Hermann and Baylor Scott & White Health. We completed a transaction of this nature in 2012 with a new health system partner in St. Louis, Missouri. We expect to add a health system partner in the future to some of the remaining 65 facilities that do not yet have such a partner.

Case Mix

The following table sets forth the percentage of internally reported revenues from our facilities for the year ended December 31, 2014 from each of the following specialties:

Specialty	
Orthopedic	43%
Pain management	11
Gynecology	2
General surgery	5
Ear, nose and throat	6
Gastrointestinal	14
Cosmetic surgery	2
Ophthalmology	8
Other	9
Total	100%

Payor Mix

The following table sets forth the percentage of the internally reported revenues from our facilities for the year ended December 31, 2014 from each of the following payors:

Payor	
Private insurance	76%
Self-pay	2
Government	20(1)
Other	2
Total	100%

(1) The percentage of our revenue attributable to government payors is approximately 18% for Medicare and 2% for Medicaid.

The following table sets forth information relating to the health system partners with which we were affiliated as of December 31, 2014:

Healthcare System	Healthcare System's Geographical Focus	Number of Facilities Operated with USPI
Single Market Systems:		
Baylor Scott & White Health	Texas	33
Centura Health	Colorado	4
Cookeville Regional Medical Center	Middle Tennessee	1
Covenant Health	Eastern Tennessee	2
Einstein Healthcare Network	Philadelphia, Pennsylvania	1
Hackensack University Medical Center	Hackensack, New Jersey	2
INTEGRIS Health	Oklahoma	1
Kennedy Health System	New Jersey	1
Legacy Health System	Portland, Oregon	2
Liberty Health	Jersey City, New Jersey	1
McLaren Health Care Corporation	Michigan	4
Memorial Hermann Healthcare System	Houston, Texas	21
Meridian Health System	New Jersey	6
Midland Memorial Hospital	Midland, Texas	1
Monongahela Valley Hospital	Pittsburgh, Pennsylvania	1
Mountain States Health Alliance	Northeast Tennessee	1
North Kansas City Hospital	Kansas City, Missouri	3
NorthShore University Health System	Chicago, Illinois	3
Orlando Health	Orlando, Florida	1
Our Lady of the Lake Regional Medical Center	Covington (New Orleans), Louisiana	1
Penn State Hershey Health System	Hershey, Pennsylvania	1
Scripps Health	San Diego, California	1
St. John Health System	Oklahoma	1
St. John's Mercy Healthcare	Missouri	1
St. Luke's Episcopal – Presbyterian Hospitals	St. Louis, Missouri	1
St. Mary's Good Samaritan	Illinois	1
The Christ Hospital	Cincinnati, Ohio	1
Multi-Market Systems:		
Adventist Health System:	12 states(a)	1
Adventist Hinsdale Hospital	Hinsdale, Illinois	
Ascension Health:	21 states and D.C.(b)	22
Carondelet Health System (2 facilities)	Blue Springs, Missouri	
St. Thomas Health Services System (15 facilities)	Middle Tennessee	
St. Vincent Health (1 facility)	Indiana	
Seton Healthcare Network (4 facilities)	Austin, Texas	
Bon Secours Health System:	Six states(c)	4
Bon Secours Health Center at Virginia Beach	Virginia Beach, Virginia	
Mary Immaculate Hospital	Newport News, Virginia	
Maryview Medical Center	Suffolk, Virginia	
St. Mary's Hospital	Richmond, Virginia	
Catholic Health Partners:	Two states(d)	
Humility of Mary Health	Canfield, Ohio	1

Healthcare System	Healthcare System's Geographical Focus	Number of Facilities Operated with USPI
CHRISTUS Health:	Six states(e)	5
CHRISTUS Health Central Louisiana (1 facility)	Alexandria, Louisiana	
CHRISTUS Spohn Health System (2 facilities)	Corpus Christi, Texas	
CHRISTUS Santa Rosa Health System (2 facilities)	San Antonio, Texas	
Dignity Health:	California, Arizona and Nevada	19
Mercy Hospital of Folsom (1 facility)	Sacramento, California	
Mercy Medical Center (2 facilities)	Redding, California	
Mercy San Juan Medical Center (1 facility)	Roseville, California	
Sierra Nevada Memorial Hospital (1 facility)	Grass Valley, California	
St. Joseph's Hospital and Medical Center (7 facilities) and Arizona Orthopedic Surgical Hospital (2 facilities)	Phoenix, Arizona	
St. Joseph's Medical Center (2 facilities)	Stockton, California	
St. Rose Dominican Hospital (2 facilities)	Las Vegas, Nevada	
Mercy Health	Four states(f)	1
Mercy Hospital – Jefferson	St. Louis, Missouri	
Providence Health System:	Five states(g)	2
Providence Holy Cross Health Center	Santa Clarita, California	
Providence Holy Cross Medical Center	Mission Hills, California	
SSM Healthcare:	Four states(h)	
SSM St. Clare Health System	St. Louis, Missouri	1
Trinity Health:	19 states(i)	
Mercy Medical Center	Sioux City, Iowa	1
Totals		154

(a) Colorado, Florida, Georgia, Illinois, Kansas, Kentucky, Missouri, North Carolina, Tennessee, Texas, West Virginia, and Wisconsin.

(b) Alabama, Arkansas, Arizona, Connecticut, District of Columbia, Georgia, Florida, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, New York, Pennsylvania, Tennessee, Texas, Washington, and Wisconsin.

(c) Florida, Kentucky, Maryland, New York, South Carolina, and Virginia

(d) Kentucky and Ohio

(e) Arkansas, Georgia, Louisiana, Missouri, New Mexico, and Texas.

(f) Arkansas, Kansas, Missouri and Oklahoma

(g) Alaska, California, Montana, Oregon, and Washington.

(h) Illinois, Missouri, Oklahoma and Wisconsin.

(i) Alabama, California, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New York, Oregon, Ohio, and Pennsylvania.

Facilities

The following table sets forth information relating to the facilities that we operated as of December 31, 2014:

	Facility	Date of Acquisition or Affiliation	Number of Operating Rooms	Percentage Owned by USPI
	United States			
	Atlanta			
	East West Surgery Center, Austell, Georgia	9/1/00(1)	3	80%
	Lawrenceville Surgery Center, Lawrenceville, Georgia	8/1/01	2	15
	Northwest Georgia Surgery Center, Marietta, Georgia	11/1/00(1)	3	15
	Orthopaedic South Surgical Center, Morrow, Georgia	11/28/03	2	15
	Resurgens Surgical Center, Atlanta, Georgia	10/1/98(1)	4	48
	Roswell Surgery Center, Roswell, Georgia	10/1/00(1)	3	15
	Surgery Center of Atlanta, Atlanta, Georgia	2/1/14	2	51
	Austin			
*	Cedar Park Surgery Center, Cedar Park, Texas	11/22/05	2	27
*	Medical Park Tower Surgery Center, Austin, Texas	8/27/10	5	31
*	Northwest Surgery Center, Austin, Texas	5/30/07	6	27
	Texan Surgery Center, Austin, Texas	6/1/03	3	55
*	Williamson Surgery Center, Round Rock, Texas	5/12/11	4	26
	Chicago			
*	Hinsdale Surgical Center, Hinsdale, Illinois	5/1/06	4	21
*	Same Day Surgery 25 East, Chicago, Illinois	10/15/04	4	45
*	Same Day Surgery North Shore, Evanston, Illinois	10/15/04	2	27
*	Same Day Surgery River North, Chicago, Illinois	10/15/04	4	33
	Corpus Christi			
*	Corpus Christi Outpatient Surgery Center, Corpus Christi, Texas	5/1/02	5	27
*	Shoreline Surgery Center, Corpus Christi, Texas	7/1/06	4	32
	Dallas/Fort Worth			
*	Baylor Medical Center at Frisco, Frisco, Texas(2)	9/30/02	11	25
*	Baylor Medical Center at Trophy Club, Trophy Club, Texas(2)	5/3/04	6	33
*	Baylor Medical Center at Uptown, Dallas, Texas(2)	4/1/03	5	18
*	Baylor Orthopedic and Spine Hospital at Arlington, Arlington, Texas(2)	2/22/10	6	25
*	Baylor Surgicare at Arlington, Arlington, Texas	2/1/99	6	26
*	Baylor Surgicare at Bedford, Bedford, Texas	12/18/98	5	41
*	Baylor Surgicare at Carrollton, Carrollton, Texas	7/1/10	2	26
*	Baylor Surgicare, Dallas, Texas	6/1/99	6	32
*	Baylor Surgicare at Denton, Denton, Texas	2/1/99	4	25
*	Baylor Surgicare at Ennis, Ennis, Texas	11/1/10(5)	3	26
*	Baylor Surgicare at Fort Worth I and II, Fort Worth, Texas	7/13/04	4	25
*	Baylor Surgicare at Garland, Garland, Texas	2/1/99	2	30
*	Baylor Surgicare at Granbury, Granbury, Texas	2/1/09	4	25
*	Baylor Surgicare at Grapevine, Grapevine, Texas	2/16/02	4	29
*	Baylor Surgicare at Heath, Rockwall, Texas	11/1/04	3	40
*	Baylor Surgicare at Lewisville, Lewisville, Texas	9/16/02	6	51
*	Baylor Surgicare at Mansfield, Mansfield, Texas	5/1/10	5	25
*	Baylor Surgicare at North Garland, Garland, Texas	5/1/05	6	26
*	Baylor Surgicare at Oakmont, Fort Worth, Texas	10/15/02	4	25
*	Baylor Surgicare at Plano, Plano, Texas	10/1/07	1	26
*	Baylor Surgicare at Plano Parkway, Plano, Texas	3/1/11	1	26

Facility		Date of Acquisition or Affiliation	Number of Operating Rooms	Percentage Owned by USPI
*	Baylor Surgical Hospital at Fort Worth, Fort Worth, Texas(2)	12/18/98	8	33
*	Baylor Surgical Hospital at Las Colinas, Irving, Texas(2)	10/20/03	5	9
*	Lone Star Endoscopy, Keller, Texas	11/1/10	1	26
*	North Central Surgical Center, Dallas, Texas(2)	12/12/05	10	18
*	North Texas Surgery Center, Dallas, Texas	12/18/98	4	29
*	Park Cities Surgery Center, Dallas, Texas	6/9/03	4	25
*	Rockwall Surgery Center, Rockwall, Texas	09/1/06	3	38
*	Surgery Center of Richardson, Richardson, Texas	11/8/12(7)	5	32
*	Texas Endoscopy – East, Plano, Texas	6/1/14— 26		
*	Texas Endoscopy – West, Plano, Texas	6/1/14	—	26
*	Tuscan Surgery Center at Las Colinas, Irving, Texas	12/1/10	1	27
*	Valley View Surgery Center, Dallas, Texas	12/18/98	4	32
	Denver			
*	Crown Point Surgical Center, Parker, Colorado	10/1/08	4	41
*	Flatirons Surgery Center, Boulder, Colorado	12/1/10	3	27
	Greenwood Ambulatory Surgery Center, Greenwood Village, Colorado	9/1/11(6)	—	63
*	Harvard Park Surgery Center, Denver Colorado	1/1/09	3	25
	Northwest Regional Ambulatory Surgery Center, Westminster, Colorado	9/1/11(6)	1	43
*	Summit View Surgery Center, Littleton, Colorado	1/1/09	3	33
	Houston			
*	Doctors Outpatient Surgicenter, Pasadena, Texas	9/1/99	5	47
*	Kingsland Surgery Center, Katy, Texas	12/31/08	4	35
*	Memorial Hermann Specialty Hospital Kingwood, Kingwood, Texas(2)	9/1/07	6	25
*	Memorial Hermann Surgery Center — Katy, Katy, Texas	1/19/07	4	10
*	Memorial Hermann Surgery Center — Memorial Village, Houston, Texas	12/1/2010	4	9
*	Memorial Hermann Surgery Center — Northwest, Houston, Texas	9/1/04	5	10
*	Memorial Hermann Surgery Center — Richmond, Richmond, Texas	12/31/09	2	26
*	Memorial Hermann Surgery Center — Southwest, Houston, Texas	9/21/06	6	10
*	Memorial Hermann Surgery Center — Sugar Land, Sugar Land, Texas	9/21/06	4	10
*	Memorial Hermann Surgery Center — Texas Medical Center, Houston, Texas	1/17/07	5	18
*	Memorial Hermann Surgery Center — The Woodlands, The Woodlands, Texas	8/9/05	4	10
*	Memorial Hermann Surgery Center — West Houston , Houston, Texas	4/19/06(4)	5	50
*	Memorial Hermann Surgery Center — Woodlands Parkway, Houston Texas	12/31/10	4	26
*	North Houston Endoscopy and Surgery, Houston, Texas	10/1/08	2	25
*	Memorial Hermann Bay Area Endoscopy, Houston, Texas	12/31/13	1	26
*	Memorial Hermann Endoscopy Center North Freeway, Houston, Texas	10/1/10	1	28
	Physicians Surgery Center of Houston, Houston, Texas	11/8/12(7)	5	95
*	Sugar Land Surgical Hospital, Sugar Land, Texas(2)	12/28/02	4	25
*	Texas International Endoscopy Center, Houston, Texas	5/1/13	1	26
*	TOPS Surgical Specialty Hospital, Houston, Texas(2)	7/1/99	7	45

Facility		Date of Acquisition or Affiliation	Number of Operating Rooms	Percentage Owned by USPI
*	United Surgery Center – Southeast, Houston, Texas	9/1/99	3	30
	Kansas City			
*	Briarcliff Surgery Center, Kansas City, Missouri	6/1/05	2	24
*	Creekwood Surgery Center, Kansas City, Missouri	7/29/98	4	33
*	Liberty Surgery Center, Liberty, Missouri	6/1/05	2	29
*	Saint Mary's Surgical Center, Blue Springs, Missouri	5/1/05	4	29
*	Midwest Physicians Surgery Center, Lee's Summit Missouri	11/1/10(5)	—	26
	Knoxville			
*	Parkwest Surgery Center, Knoxville, Tennessee	7/26/01	5	23
*	Physician's Surgery Center of Knoxville, Knoxville, Tennessee	1/1/08	5	27
	Las Vegas			
*	Durango Outpatient Surgery Center, Las Vegas, Nevada	12/9/08	4	45
*	Parkway Surgery Center, Henderson, Nevada	8/3/98	5	26
	Los Angeles			
	Coast Surgery Center of South Bay, Torrance, California	12/18/01	3	23
	Pacific Endo-Surgical Center, Torrance, California	8/1/03	1	55
*	San Fernando Valley Surgery Center, Mission Hills, California	11/1/04	4	27
	San Gabriel Valley Surgical Center, West Covina, California	11/16/01	3	47
*	Santa Clarita Ambulatory Surgery Center, Santa Clarita, California	3/7/06	3	33
	The Center for Ambulatory Surgical Treatment, Los Angeles, California	11/14/02	4	20
	Michigan			
*	Clarkston Surgery Center, Clarkston, Michigan	6/1/09	4	37
*	Genesis Surgery Center, Lansing, Michigan	11/1/06	4	33
*	Lansing Surgery Center, Lansing, Michigan	11/1/06	4	33
	Matrix Surgery Center, Saginaw, Michigan	9/1/11(6)	3	44
*	Utica Surgery and Endoscopy Center, Utica, Michigan	4/1/07	3	34
	Nashville			
*	Baptist Ambulatory Surgery Center, Nashville, Tennessee	3/1/98(1)	6	28
*	Baptist Plaza Surgicare, Nashville, Tennessee	12/3/03	9	30
*	Center for Spinal Surgery, Nashville, Tennessee(2)	12/31/08	6	20
*	Clarksville Surgery Center, Clarksville, Tennessee	10/1/12	3	26
*	Eye Surgery Center of Nashville, Nashville, Tennessee	11/1/10(5)	1	26
*	Franklin Endoscopy Center, Franklin, Tennessee	11/1/10(5)	—	25
*	Lebanon Endoscopy Center, Lebanon, Tennessee	11/1/10(5)	—	50
*	Middle Tennessee Ambulatory Surgery Center, Murfreesboro, Tennessee	7/29/98	4	40
*	Mid-State Endoscopy Center, Murfreesboro, Tennessee	4/6/11	2	15
*	Northridge Surgery Center, Nashville, Tennessee	4/19/06(4)	5	32
*	Patient Partners Surgery Center, Gallatin, Tennessee	11/1/10(5)	2	31
*	Physicians Pavilion Surgery Center, Smyrna, Tennessee	7/29/98	4	49
*	Saint Thomas Surgicare, Nashville, Tennessee	7/15/02	5	34
*	Tennessee Sports Medicine Surgery Center, Mt. Juliet, Tennessee	11/1/10(5)	4	18
	New Jersey			
*	Central Jersey Surgery Center, Estontown, New Jersey	11/1/04	3	30
*	Endoscopy Center of Bergen County, Paramus, New Jersey	9/1/12	4	26
*	Hackensack Endoscopy Center, Hackensack, New Jersey	9/1/12	2	27

Facility		Date of Acquisition or Affiliation	Number of Operating Rooms	Percentage Owned by USPI
*	Lakewood Surgery Center, Lakewood, New Jersey	9/1/11(6)	2	35
	Millennium Surgical Center, Cherry Hill, New Jersey	9/1/11(6)	4	55
*	Liberty Ambulatory Surgery Center, Jersey City, New Jersey	6/9/11	3	28
	Metropolitan Surgery Center, Hackensack, New Jersey	11/1/11	2	51
*	Northern Monmouth Regional Surgery Center, Manalapan, New Jersey	7/10/06	4	13
*	Select Surgical Center at Kennedy, Sewell, New Jersey	10/29/09	3	25
*	Shore Outpatient Surgicenter, Lakewood, New Jersey	11/1/04	3	38
*	Shrewsbury Surgery Center, Shrewsbury, New Jersey	4/1/99	4	14
	Somerset Ambulatory Surgical Center, Somerville, New Jersey	4/1/14	2	55
	Suburban Endoscopy Services, Verona, New Jersey	4/19/06(4)	2	51
	Surgical Center of Northwest Jersey, Denville, New Jersey	7/1/14	2	56
	Surgical Specialists at Princeton, Princeton, New Jersey	9/1/11(6)	3	16
*	Toms River Surgery Center, Toms River, New Jersey	3/15/02	4	15
	Phoenix			
*	Arizona Orthopedic Surgical Hospital, Chandler, Arizona(2)	5/19/04	6	39
*	Chandler Endoscopy Center, Chandler, Arizona	3/1/12	1	26
*	Desert Ridge Outpatient Surgery Center, Phoenix, Arizona	3/30/07	4	25
*	Metro Surgery Center, Phoenix, Arizona	4/19/06(4)	4	27
*	OASIS Hospital, Phoenix, Arizona(2)	6/27/11	8	50
	Physicians Surgery Center of Tempe, Tempe, Arizona	4/19/06(4)	2	10
*	St. Joseph's Outpatient Surgery Center, Phoenix, Arizona	9/2/03	8	26
*	Surgery Center of Peoria, Peoria, Arizona	4/19/06(4)	3	28
*	Surgery Center of Scottsdale, Scottsdale, Arizona	4/19/06(4)	4	25
	Surgery Center of Gilbert, Gilbert, Arizona	4/19/06(4)	3	22
	Tempe New Day Surgery Center	11/8/12(7)	2	95
*	Warner Outpatient Surgery Center, Chandler, Arizona	7/1/99	4	29
	Pennsylvania			
*	Einstein Montgomery Surgery Center, East Norriton, Pennsylvania	12/21/12	4	15
*	Hershey Outpatient Surgery Center, Hershey, Pennsylvania	9/1/11(6)	7	28
	Gamma Surgery Center, Pittsburgh, Pennsylvania	9/1/11(6)	2	51
	Reading Surgery Center, Wyomissing, Pennsylvania	7/1/04	3	25
*	Southwestern Ambulatory Surgery Center, Pittsburgh, Pennsylvania	9/1/11(6)	4	24
	Portland			
	Cascade Spine Center, Tualatin, Oregon	9/1/11(6)	—	20
*	East Portland Surgical Center, Portland, Oregon	12/31/09	4	33
*	Northwest Surgery Center, Portland, Oregon	12/1/08	3	26
	Redding			
*	Court Street Surgery Center, Redding, California	4/19/06(4)	2	32
*	Mercy Surgery Center, Redding, California	3/1/08	4	32
	Sacramento			
*	Folsom Outpatient Surgery Center, Folsom, California	6/1/05	2	30
*	Grass Valley Surgery Center, Grass Valley, California	7/1/10	2	23
	Pain Diagnostic and Treatment Center, Sacramento, California	9/1/11(6)	1	64
*	Roseville Surgery Center, Roseville, California	7/1/06	2	28
	San Antonio			
*	Alamo Heights Surgery Center, San Antonio, Texas	12/1/04	4	15

Facility		Date of Acquisition or Affiliation	Number of Operating Rooms	Percentage Owned by USPI
*	Alamo Heights Surgical Hospital San Antonio, Texas(2)	10/1/14	17	15
	San Antonio Endoscopy Center, San Antonio, Texas	5/1/05	1	53
	Turning Point Specialty Surgery Center, San Antonio, Texas	11/8/12(7)	2	85
	San Diego			
*	Scripps Encinitas Surgery Center, Encinitas, California	2/6/08	3	20
	Encinitas Surgery Center, Encinitas, California	12/30/11	—	51
	St. Louis			
	Advanced Surgical Care, Creve Coeur, Missouri	1/1/06	2	37
	Chesterfield Surgery Center, Chesterfield, Missouri	1/1/06	2	59
	Frontenac Surgery and Spine Care Center, Frontenac, Missouri	5/1/07	2	40
*	Gateway Endoscopy Center, St. Louis, Missouri	5/1/10	—	35
	Manchester Surgery Center, St. Louis, Missouri	2/1/07	3	63
	Mason Ridge Surgery Center, St. Louis, Missouri	2/1/07	2	53
	Mid Rivers Surgery Center, Saint Peters, Missouri	1/1/06	2	49
	Old Tesson Surgery Center, St. Louis, Missouri	8/1/08	3	60
	Olive Surgery Center, St. Louis, Missouri	1/1/06	2	53
	Riverside Ambulatory Surgery Center, Florissant, Missouri	8/1/06	2	57
	South County Outpatient Endoscopy Services, St. Louis, Missouri	10/1/08	2	35
*	SSM St. Clare Surgical Center, Fenton, Missouri	10/23/09	3	20
*	St. Louis Surgical Center, Creve Coeur, Missouri	4/1/10	7	38
	Sunset Hills Surgery Center, St. Louis, Missouri	1/1/06	2	61
*	Twin Cities Ambulatory Surgery Center, St. Louis, Missouri	9/1/08	2	50
	Webster Surgery Center, Webster Groves, Missouri	3/1/07	2	41
	Virginia			
*	Bon Secours Surgery Center at Harbour View, Suffolk, Virginia	11/12/07	6	21
*	Bon Secours Surgery Center at Virginia Beach, Virginia Beach, Virginia	5/30/07	2	24
*	Mary Immaculate Ambulatory Surgical Center, Newport News, Virginia	7/19/04	3	16
*	St. Mary's Ambulatory Surgery Center, Richmond, Virginia	11/29/06	4	14
	Surgi-Center of Central Virginia, Fredericksburg, Virginia	11/29/01	4	60
	Additional Markets			
*	Ambulatory Surgery Center of Stockton, Stockton, California	12/28/12	3	26
*	Beaumont Surgical Affiliates, Beaumont, Texas	4/19/06(4)	6	32
	Chattanooga Pain Center, Chattanooga, Tennessee	9/1/11(6)	3	43
	Chico Surgery Center, Chico, California	4/19/06(4)	3	63
*	CHRISTUS Cabrini Surgery Center, Alexandria, Louisiana	6/22/07	4	22
	Day-Op Center of Long Island, Mineola, New York(3)	12/4/98	4	100
	Destin Surgery Center, Destin, Florida	9/25/02	2	55
	Effingham Ambulatory Surgery Center, Effingham, Illinois	12/31/12	5	54
	El Mirador Surgery Center, Palm Springs, California	11/1/10	6	28
*	Good Samaritan Surgery Center, Mt. Vernon, Illinois	2/7/13	3	31
*	Hacienda Surgery Center, Pleasanton, California	10/1/14	3	26
	Indiana Specialty Surgery Center, Bloomington, Indiana	3/1/14	2	57

	Facility	Date of Acquisition or Affiliation	Number of Operating Rooms	Percentage Owned by USPI
	MedPlex Outpatient Surgery Center, Birmingham, Alabama	11/1/10(5)	4	21
*	Mountain Empire Surgery Center, Johnson City, Tennessee	2/20/00(1)	4	16
	New Horizons Surgery Center, Marion, Ohio	4/19/06(4)	2	12
	New Mexico Orthopaedic Surgery Center, Albuquerque, New Mexico	2/29/00(1)	6	51
	North Haven Surgery Center, North Haven, Connecticut	9/1/11(6)	1	23
*	Oklahoma Center for Orthopedic MultiSpecialty Surgery, Oklahoma City, Oklahoma(2)	8/2/04	4	23
*	Our Lady of the Lake Pontchartrain Surgery Center, Covington, Louisiana	12/31/12	2	27
	Physicians Surgery Center of Chattanooga, Chattanooga, Tennessee	11/1/10(5)	4	56
	Redmoad Surgery Center, Redmond, Oregon	4/19/06(4)	2	72
*	Siouxland Surgical Hospital, Dakota Dunes, South Dakota(2)	7/1/14	14	25
*	St. Joseph's Surgery Center, Stockton, California	2/1/09	6	5
*	Surgery Center of Canfield, Canfield, Ohio	4/19/06(4)	3	26
	Surgery Center of Columbia, Columbia, Missouri	8/1/06	2	57
	Surgery Center of Fort Lauderdale, Fort Lauderdale, Florida	11/1/04	4	47
	SurgiCenter of Baltimore, Owings Mills, Maryland	11/1/10(5)	5	49
*	Terre Haute Surgical Center, Terre Haute, Indiana	12/19/07	2	20
	Teton Outpatient Services, Jackson, Wyoming	8/1/98(1)	2	51
*	Texas Surgical Center, Midland, Texas	2/1/12	2	31
*	The Christ Hospital Spine Surgery Center, Cincinnati, Ohio	12/31/09	3	26
	Titusville Center for Surgical Excellence, Titusville, Florida	9/1/11(6)	2	31
	Tri-City Orthopaedic Center, Richland, Washington(3)	4/19/06(4)	2	17
*	Tullahoma Surgery Center, Tullahoma, Tennessee	12/31/10	2	26
*	Tulsa Surgery Center, Tulsa, Oklahoma	10/1/09	4	25
*	Upper Cumberland Physician Surgery Center, Cookeville, Tennessee	11/1/10(5)	2	11
*	University Surgical Center, Winter Park, Florida	10/15/98	3	46
	Victoria Ambulatory Surgery Center, Victoria, Texas	4/19/06(4)	2	59

* Facilities jointly owned with health system partners.

(1) Indicates date of acquisition by OrthoLink Physician Corporation. We acquired OrthoLink in February 2001.

(2) Surgical hospitals, all of which are licensed and equipped for overnight stays.

(3) Operated through a consulting and administrative agreement.

(4) Indicates the date of our acquisition of Surgis.

(5) Indicates the date of our acquisition of HealthMark.

(6) Indicates the date of our acquisition of Titan.

(7) Indicates the date of our acquisition of AIGB Holdings, Inc. (True Results).

We lease the majority of the facilities where our various surgery centers and surgical hospitals conduct their operatiuns. Our leases have initial terms ranging from five to twenty years and most of the leases contain options to extend the lease period, in some cases for up to ten additional years.

Our corporate headquarters is located in a suburb of Dallas, Texas. We currently lease approximately 100,000 square feet of space at 15305 Dallas Parkway, Addison, Texas. The lease expires in October 2020.

We also lease approximately 55,000 square feet of total additional space in Brentwood, Tennessee; Chicago, Illinois; Houston, Texas; St. Louis, Missouri; Tinton Falls, New Jersey; Denver, Colorado; and Pasadena, California for regional offices. These leases expire between December 2016 and December 2021.

Acquisitions and Development

We have projects under development which are in various stages of negotiation with both current and prospective joint venture partners, and will result in our operating additional facilities in 2015. While our history suggests that many of these projects will culminate with the opening or acquisition of a profitable surgical facility, we can provide no assurance that any of these projects will reach that stage or will be successful thereafter.

Marketing

Our sales and marketing efforts are directed primarily at physicians, who perform or are likely to perform surgical procedures in our facilities. We market our facilities to physicians by emphasizing (1) the high level of patient and physician satisfaction with our facilities, which is based on surveys we take conceming our facilities, (2) the quality and responsiveness of our services, (3) the practice efficiencies provided by our facilities, and (4) the benefits of our affiliation with our health system partners, if applicable. We also directly negotiate, together in some instances with our health system partners, agreements with third-party payors, which generally focus on the pricing, number of facilities in the market and affiliation with physician groups in a particular market. Maintaining access to physicians and patients through third-party payur contracting is essential for the economic viability of most of our facilities.

Competition

In all of our markets, our facilities compete with other providers, including major acute care hospitals and other surgery centers. Hospitals have various competitive advantages over us, including their established managed care contracts, community position, physician loyalty and geographical convenience for physicians' inpatient and outpatient practices. However, we believe that, in comparison to hospitals with which we compete, our surgery centers and surgical hospitals compete favorably on the basis of cost, quality, efficiency and responsiveness to physician needs in a more comfortable environment for the patient.

We compete with other providers in each of our markets for patients, physicians and for contracts with insurers or managed care payurs. Competition for managed care contracts with other providers is focused on the pricing, number of facilities in the market and affiliation with key physician groups in a particular market. We believe that our relationships with our health system partners enhance our ability to compete for managed care contracts. We also encounter competition with other companies for acquisition and development of facilities and in the United States for strategic relationships with local health systems and physicians.

There are several cumpanies, both public and private, that acquire and develop freestanding multi-specialty surgery centers and surgical hospitals. Some of these competitors have greater resources than we do. The principal competilive factors lhat affect our ability and the ability of uur competitors to acquire surgery centers and surgical hospitals are price, experience, reputation and access to capital. Further, many physician groups develop surgery centers without a corporale partner, and this presents a compelitive threat to our company.

Employees

As of December 31, 2014, we employed approximately 10,600 people, 7,300 of whom are full-time employees and 3,300 of whom are part-time employees. The physicians that affiliate with us and use our facilities are not our employees, except in a limited number of circumstances. However, we generally offer the physicians the opportunity to purchase equity interests in the facilities they use.

Professional and General Liability Insurance

We maintain professional and general liability insurance through a wholly-owned captive insurance company. We make premium payments to the captive insurance company and accrue for claims costs based on actuarially predicted ultimate losses and the captive insurance company then pays administrative fees and the insurance claims. We also maintain business interruption, property damage and umbrella insurance with third-party providers. The governing documents of each of our surgical facilities require physicians who conduct surgical procedures at those facilities to maintain stated amounts of insurance. Our insurance policies are generally subject to annual renewals. We believe that we will be able to renew current policies or otherwise obtain comparable insurance coverage at reasonable rates. However, we have no control over the insurance markets and can provide no assurance that we will economically be able to maintain insurance similar to our current policies.

Government Regulation

General

The healthcare industry is subject to extensive regulation by federal, state and local governments. Government regulation affects our business by controlling growth, requiring licensing or certification of facilities, regulating how facilities are used and controlling payment for services provided. Further, the regulatory environment in which we operate may change significantly in the future. While we believe we have structured our agreements and operations in material compliance with applicable law, there can be no assurance that we will be able to successfully address changes in the regulatory environment.

Every state imposes licensing and other requirements on healthcare facilities. In addition, many states require regulatory approval, including certificates of need, before establishing or expanding various types of healthcare facilities, including ambulatory surgery centers and surgical hospitals, offering services or making capital expenditures in excess of statutory thresholds for healthcare equipment, facilities or programs. In addition, the federal Medicare program imposes additional conditions for coverage and payment rules for services furnished to Medicare beneficiaries. We may become subject to additional regulations as we expand our existing operations and enter new markets.

In addition to extensive existing government healthcare regulation, there have been numerous initiatives on the federal and state levels for comprehensive reforms affecting the payment for and availability of healthcare services. We believe that these healthcare reform initiatives will continue during the foreseeable future. If adopted, some aspects of proposed reforms, such as further reductions in Medicare or Medicaid payments, or additional prohibitions on physicians' financial relationships with facilities to which they refer patients, could adversely affect us.

We believe that our business operations materially comply with applicable law. However, we have not received a legal opinion from counsel or from any federal or state judicial or regulatory authority to this effect, and many aspects of our business operations have not been the subject of state or federal regulatory scrutiny or interpretation. Some of the laws applicable to us are subject to limited or evolving interpretations; therefore, a review of our operations by a court or law enforcement or regulatory authority might result in a determination that could have a material adverse effect on us. Furthermore, the laws applicable to us may be amended or interpreted in a manner that could have a material adverse effect on us. Our ability to conduct our business and to operate profitably will depend in part upon obtaining and maintaining all necessary licenses, certificates of need and other approvals, and complying with applicable healthcare laws and regulations.

Healthcare Reform

The Acts were signed into law on March 23, 2010 and March 30, 2010, respectively. The Acts are intended to provide coverage and access to substantially all Americans, to increase the quality of care provided and to reduce the rate of growth in healthcare expenditures. The changes include, among other things, expanding Medicare's use of value-based purchasing programs, tying facility payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, reducing Medicare and Medicaid payments, expanding Medicaid eligibility, requiring many health plans (including Medicare) to cover, without cost-sharing, certain preventative services, and expanding access to health insurance. The Acts also place limitations on the Stark Law exception that allows physicians to invest in hospitals if the physicians' investments are in the entire hospital and not just a department of the hospital (the "whole hospital exception"). Among other things, the Acts prohibit hospitals from increasing the percentages of the total value of the ownership interests held in the hospital by physicians after March 23, 2010, as well as place restrictions on the ability of a hospital subject to the whole hospital exception to add operating rooms, procedure rooms and beds. The Acts provide for additional enforcement tools, cooperation between agencies, and funding for enforcement. The Acts mandate reductions in reimbursement, such as adjustments to the hospital inpatient and outpatient prospective payment system market basket updates and productivity adjustments to Medicare's annual inflation updates, which became effective in 2010 and 2012.

The Acts also make several significant changes to healthcare fraud and abuse laws, provide additional enforcement tools to the government, increase cooperation between agencies by establishing mechanisms for the sharing of information and enhance criminal and administrative penalties for non-compliance. For example, the Acts (i) provide $350 million in increased federal funding over the next 10 years to fight healthcare fraud, waste and abuse; (ii) expand the scope of the recovery audit contractor program to include Medicaid and Medicare Advantage plans; (iii) authorize the Department of Health and Human Services, in consultation with the Office of Inspector General, to suspend Medicare and Medicaid payments to a provider of services or a supplier "pending an investigation of a credible allegation of fraud;" (iv) provide Medicare contractors with additional flexibility to conduct random prepayment reviews; and (iv) strengthen the rules for returning overpayments made by governmental health programs, including expanding False Claims Act liability to extend to failures to timely repay identified overpayments.

As a result of the Acts, we expect enhanced scrutiny of healthcare providers' compliance with state and federal regulations, infection control standards and other quality control measures. Effective January 15, 2009, CMS promulgated three national coverage determinations that prevent Medicare from paying for certain serious, preventable medical errors performed in any healthcare facility, such as surgery performed on the wrong patient. Several commercial payors also do not reimburse providers for certain preventable adverse events. The Acts also contain a number of provisions that are intended to improve the quality of care that is provided to Medicare and Medicaid beneficiaries. For example, beginning July 1, 2011, the Acts prohibited Medicaid programs from using federal funds to reimburse providers for the costs of care needed to treat hospital acquired conditions ("HACs"). Beginning in federal fiscal year ("FY") 2015, the Acts mandate a 1% reduction in Medicare payments for hospitals that were in the highest quartile of national risk-adjusted HAC rates for the previous federal fiscal year (the "HAC Reduction Program"). In December 2014, CMS announced that 724 hospitals would be subject to the HAC Reduction Program for FY 2015. In addition, the Acts required CMS to examine whether the existing case-based HAC payment policy (as distinguished from the new rate-based HAC Reduction Program) should be expanded to cover ASCs and other facilities. In a December 2012 report to Congress, CMS concluded that extending the case-based HAC policy to ASCs was not feasible given the differing payment systems involved. Instead, CMS recommended exploration of other payment policies designed to reduce HACs at ASCs and other facilities. We could be subject to greater reduction in Medicare or Medicaid reimbursement in the future if such policies are ultimately adopted and applied to ASCs.

In addition, federal law authorizes CMS to require ambulatory surgery centers to submit data on certain quality measures or incur a penalty: namely, a two percentage point reduction to any annual increase in the ASC payment rate for that calendar year ("CY"). CMS first exercised this authority in November 2011, requiring

ASCs to report data initially on five specified quality measures beginning October 1, 2012, with penalties to be enforced beginning with the CY 2014 payment year. Under the most recent ASC payment and quality reporting rules promulgated by CMS in November 2014, the number of quality measures that must be reported has grown to 12. In addition, effective October 1, 2012, Medicare began offering incentive payments to hospitals for delivering high-quality care through a value-based purchasing program. The incentives will be funded through a one percent deduction in the base operating diagnosis-related group payments for hospitals' discharges. The reductions will increase over subsequent years. Hospitals must meet or exceed a baseline score on a set of predetermined clinical and patient experience measures. With regard to ambulatory surgery centers, the Department of Health and Human Services submitted a report to Congress in April 2011 outlining the Department's plan to implement a value-based purchasing program. While the report describes efforts to improve quality and payment efficiency in ambulatory surgery centers and examines the steps required to design and implement an ambulatory surgery center valued-based program, Congress has not yet authorized CMS to implement a valued-based program for ambulatory surgery centers.

Accountable Care Organizations

On October 31, 2011, CMS issued final regulations for Accountable Care Organizations ("ACOs"), which were created under the Acts and intended to allow providers, including hospitals, physicians and other designated professionals and suppliers, to coordinate care for Medicare beneficiaries through participation in a Medicare Shared Savings Program (the "Shared Savings Program" or "Program"). The Shared Savings Program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve certain savings benchmarks and quality performance standards will be eligible to share in a portion of the amounts saved under the Program, but will eventually have to share in financial losses as well. The 2011 regulations detailed certain key characteristics of an ACO and outlined other Program requirements, including those governing the scope and length of an ACO's contract with CMS, the required governance of an ACO, the assignment of Medicare beneficiaries to an ACO, the payment models under which an ACO can share in cost savings, and the quality and other reporting requirements expected of an ACO. On December 1, 2014, CMS issued proposed rules that would implement several changes designed to encourage greater ACO participation in the Shared Savings Program. The proposed rule would extend the period in which ACOs can participate in the risk-free track of the Program without penalties; it also incentivizes continued participation by higher-performing ACOs through greater shared savings opportunities, and proposes certain operational streamlining initiatives. Patient and provider participation in ACOs and the Shared Savings Program is voluntary. We will continue to monitor developments with the implementation of the ACO regulations and their effect on our business in order to react accordingly.

Licensure and certificate-of-need regulations

Capital expenditures for the construction of new facilities, the addition of capacity or the acquisition of existing facilities may be reviewable by state regulators under statutory schemes that are sometimes referred to as certificate of need laws. States with certificate of need laws place limits on the construction and acquisition of healthcare facilities and the expansion of existing facilities and services. In these states, approvals are required for capital expenditures exceeding certain specified amounts and that involve certain facilities or services, including ambulatory surgery centers and surgical hospitals.

State certificate of need laws generally provide that, prior to the addition of new beds, the construction of new facilities or the introduction of new services, a designated state health planning agency must determine that a need exists for those beds, facilities or services. The certificate of need process is intended to promote comprehensive healthcare planning, assist in providing high quality healthcare at the lowest possible cost and avoid unnecessary duplication by ensuring that only those healthcare facilities that are needed will be built.

Typically, the provider of services submits an application to the appropriate agency with information concerning the area and population to be served, the anticipated demand for the facility or service to be provided, the amount of capital expenditure, the estimated annual operating costs, the relationship of the proposed facility or service to the overall state health plan and the cost per patient day for the type of care contemplated. The

issuance of a certificate of need is based upon e finding of need by the agency in accordance with criteria set forth in certificate of need laws and state and regional health facilities plans. If the proposed facility or service is found to be necessary and the applicant to be the appropriate provider, the agency will issue a certificate of need containing a maximum amount of expenditure and a specific time period for the holder of the certificate of need to implement the approved project.

Our healthcare facilities also are subject to state licensing requirements for medical providers. Our facilities have licenses to operate as ASCs in the states in which they operate. Our surgical facilities that are licensed as ASCs must meet all applicable requirements for ASCs. In addition, even though our surgical facilities that are licensed as hospitals primarily provide surgical services, they must meet all applicable requirements for hospital licensure. To assure continued compliance with these regulations, governmental and other authorities periodically inspect our surgical facilities. The failure to comply with these regulations could result in the suspension or revocation of a facility's license. In addition, based on the specific operations of our surgical facilities, some of these facilities maintain a pharmacy license, a controlled substance registration, and a clinical laboratory certification waiver, as required by applicable law.

Our healthcare facilities are also subject to state and local licensing regulations ranging from the adequacy of medical care to compliance with building codes and environmental protection laws. To assure continued compliance with these regulations, governmental and other authorities periodically inspect our facilities. The failure to comply with these regulations could result in the suspension or revocation of a healthcare facility's license.

Our healthcare facilities receive accreditation from the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, Inc., nationwide commissions which establish standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of various types of healthcare facilities. Generally, our healthcare facilities must be in operation for at least six months before they are eligible for accreditation. As of December 31, 2014, substantially all of our eligible healthcare facilities had been accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, Inc. From time to time, a few of our surgical facilities are in the process of applying for such accreditation. Many managed care companies and third-party payors require our facilities to be accredited in order to be considered a participating provider under their health plans.

Medicare and Medicaid Participation in Short-Stay Surgical Facilities

Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to social security benefits who are 65 or older or who are disabled. Medicaid is a health insurance program jointly funded by state and federal governments that provides medical assistance to qualifying low income persons. Each state Medicaid program has the option to determine coverage and payment rates for surgical services furnished in hospitals and in ASCs. All of the states in which we currently operate cover Medicaid surgical facility services provided in these settings; however, these states may not continue to cover short-stay surgical facility services and states into which we expand our operations may not cover or continue to cover short-stay surgical facility services.

A portion of our revenues are attributable to payments received from the Medicare and Medicaid programs. For the years ended December 31, 2014, 2013 and 2012, Medicare and Medicaid comprised 38%, 37%, and 35%, respectively, of our case volumes. These payments represented, however, a significantly lower percentage of our overall revenues due to the lower reimbursement provided by government payors in comparison to private payors. For example, Medicare and Medicaid contributed approximately 18% and 2% respectively of our 2014 patient service revenues despite the fact that governmental payors represented a total of 38% of our case volume during 2014.

In order to participate in the Medicare program, our facilities (known to Medicare as "providers") must satisfy provider enrollment requirements as well as regulatory conditions of participation ("COPs") for hospitals and conditions for coverage ("CFCs") for ASCs. Each facility can meet its COPs or CFCs requirements through accreditation with The Joint Commission on Accreditation of Healthcare Organizations or other CMS-approved accreditation organizations, or through direct surveys by CMS. Substantially all of our short-stay surgical facilities in the United States are enrolled in Medicare and certified to participate in the Medicare program or, with respect to newly acquired or developed facilities, are awaiting enrollment and certification to participate in the Medicare program. We have established systems to ensure our facilities' compliance with their enrollment obligations, including certain ongoing reporting obligations. In addition, we have implemented ongoing quality assurance activities to monitor and to ensure our facilities' compliance with their COPs or CFCs. Any failure by a facility to maintain compliance with its enrollment obligations, COPs or CFCs could result in the loss of the facility's Medicare billing privileges and provider agreement. The loss of Medicare billing privileges results in the termination of the facility's enrollment in the Medicare program and may preclude the facility from re-enrolling in the Medicare program for up to three years. In addition, federal regulations require states to deny Medicaid program enrollment or to terminate Medicaid program enrollment for any facility that has been terminated from Medicare or any other state's Medicaid program. Conversely, federal regulations permit CMS to revoke Medicare billing privileges when a state Medicaid agency terminates, revokes, or suspends a facility's Medicaid enrollment or billing privileges.

CMS also requires hospitals to disclose physician ownership to patients. Congress now requires written disclosures of physician ownership interests to hospital patients, on the hospital's website and in any advertising. Federal legislation also imposes a requirement that any hospital that does not have 24/7 physician coverage inform patients of this fact and receive signed acknowledgments from the patients of the disclosure. A hospital's provider agreement may be terminated if it fails to make such disclosures. We believe all of our facilities meet their disclosure obligations.

Medicare's payment for short-stay surgical procedures, whether performed in a hospital or an ASC, is based upon a prospectively determined fixed payment amount. For most covered surgical procedures, the payment rate is the product of the relative weight determined for the procedure and a conversion factor and then adjusted for variations in labor costs across geographic areas. The hospital outpatient prospective payment system conversion factor is generally higher than the conversion factor set for procedures in ASCs. As a result, Medicare payment rates for a procedure are typically lower in ASCs than in hospital surgical facilities. Congress requires Medicare to update the conversion factor used to determine payment rates under the hospital outpatient prospective payment system and the ASC payment methodology annually. Medicare's annual update to the hospital outpatient prospective payment system is equal to the hospital inpatient market basket percentage increase; the ASC annual payment update is based on the Consumer Price Index. Medicare thus uses a lower inflationary factor for ASC payments than for hospital surgical facilities. There is no certainty that the annual update in a given year will equal or exceed the update in the previous year. In addition, starting in calendar year 2011 for ASCs and in calendar year 2012 for hospitals, the annual update applicable to our facilities has been reduced by a productivity adjustment. The amount of that reduction is based on the projected nationwide productivity gains over the preceding 10 years. To determine the projection, Medicare uses the Bureau of Labor Statistics 10-year moving average of changes in specified economy-wide productivity.

Medicare's payments for physician services under the physician fee schedule are updated annually based in part on the sustainable growth rate ("SGR") formula, which weighs factors such as healthcare costs and gross domestic product. Every year since 2003, Congress has overridden scheduled reductions to physician payment rates that would have otherwise taken effect under the SGR formula. In 2014, Congress and the President again acted to defer scheduled rate cuts: the Protecting Access to Medicare Act of 2014 (P.L. 113-93), signed into law on April 1, 2014, freezes the SGR conversion factor through March 31, 2015, thus avoiding a 24% reduction in physician payment rates at a cost of approximately $20 billion. In 2014, as in other recent years, the SGR "patch" was paid for through reductions in various Medicare and Medicaid payments to hospitals and other providers. Additional reductions in Medicare reimbursement could have a negative impact on various factors that affect the profitability of USPI, such as the number of overall procedures performed at the ASCs.

Our hospitals and ASCs are subject to other payment adjustments. Since calendar year 2008, Medicare has required hospitals to report specified hospital outpatient quality measures in order to avoid reductions in their annual payment updates. In November 2011, as stated above, CMS introduced a similar quality reporting program for ASCs. Like hospitals, ASCs that fail to report on the required measures in any year will face reductions in their Medicare payment rates in a subsequent year. In addition, Congress has authorized CMS to establish a value-based purchasing program for Medicare hospital services. CMS has implemented value-based purchasing for hospital inpatient services but has not yet done so for hospital outpatient services. Similarly, Congress has directed CMS to develop a plan to implement a value-based purchasing program for payments to ASCs, although Congress still must provide statutory authority to implement such a program for ASCs. Failure by any of our facilities to meet Medicare's quality measures and any performance standards implemented under value-based purchasing regulations may adversely affect such facilities' net revenues from the Medicare program.

The various state Medicaid programs also pay us a fixed payment for our services, which amount varies from state to state. There is no certainty that the amount of Medicaid or Medicare payments we have received in prior years will continue at current levels. Both the Medicaid and Medicare programs are subject to statutory and regulatory changes, possible retroactive and prospective rate adjustments, administrative rulings, freezes and funding reductions, all of which may adversely affect the level of payments to our short-stay surgical facilities. The ultimate impact of the changes in Medicare reimbursement will depend on a number of factors, including the procedure mix at our facilities and our ability to realize an increased procedure volume.

Workers' Compensation

Certain of our facilities provide workers' compensation services. In the past, workers' compensation payors generally reimbursed surgical facilities a higher percentage of the facilities' charges than other payors. However, in recent years, a number of states have implemented or are considering implementing workers' compensation fee schedules with rates generally lower than what our facilities have historically been paid for the same services.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of diagnosis related group classifications and the appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided or assess fines and also have the authority to recommend to the U.S. Department of Health and Human Services that a provider which is in substantial noncompliance with the standards of the quality improvement organization be excluded from participatian in the Medicare program.

Federal Anti-Kickback Statute and Medicare Fraud and Abuse Laws

State and federal laws regulate relationships among providers of healthcare services, including employment or service contracts and investment relationships. These restrictions include a federal criminal law, referred to herein as the anti-kickback statute, that prohibits offering, paying, soliciting or receiving, directly or indirectly, any form of remuneration in return for:

- referring an individual to a person for furnishing, or arranging for the furnishing of, any service or item payable under a federal healthcare program, including Medicare or Medicaid, or
- purchasing, leasing or ordering, or arranging for or recommending purchasing, leasing or ordering, any good, facility, service or item for which payment may be made in whole or in part by a federal healthcare program, including Medicare or Medicaid.

A violation of the anti-kickback statute constitutes a felony. Potential sanctions include imprisonment of up to five years, criminal fines of up to $25,000, civil money penalties of up to $50,000 per act plus three times the remuneration offered or three times the amount claimed and exclusion from all federally funded healthcare programs. The applicability of these provisions to some forms of business transactions in the healthcare industry has not yet been subject to judicial or regulatory interpretation. Moreover, several federal courts have held that the anti-kickback statute can be violated if only one purpose (not necessarily the primary purpose) of the transaction is to induce or reward a referral of business, notwithstanding other legitimate purposes.

Pursuant to the anti-kickback statute, and in an effort to reduce potential fraud and abuse relating to federal healthcare programs, the federal government has announced a policy of a high level of scrutiny of joint ventures and other transactions among healthcare providers. The Office of the Inspector General of the Department of Health and Human Services ("OIG") closely scrutinizes healthcare joint ventures involving physicians and other referral sources. The OIG published a fraud alert that outlined questionable features of "suspect" joint ventures in 1989 and a Special Advisory Bulletin related to contractual joint ventures in 2003, and the agency has continued to rely on fraud alerts in later pronouncements.

The anti-kickback statute contains provisions that insulate certain transactions from liability. In addition, pursuant to the provisions of the anti-kickback statute, the OIG has also published regulations that exempt additional practices from enforcement under the anti-kickback statute. These statutory exceptions and regulations, known as "safe harbors," if fully complied with, assure participants in particular types of arrangements that the OIG will not treat their participation in that arrangement as a violation of the anti-kickback statute. The statutory exceptions and safe harbor regulations do not expand the scope of activities that the anti-kickback statute prohibits, nor do they provide that failure to satisfy the terms of a safe harbor constitutes a violation of the anti-kickback statute. The OIG has, however, indicated that failure to satisfy the terms of an exception or a safe harbor may subject an arrangement to increased scrutiny. Therefore, if a transaction or relationship does not fit within an exception or safe harbor, the facts and circumstances as well as intent of the parties related to a specific transaction or relationship must be examined to determine whether or not any illegal conduct has occurred.

Our partnerships and limited liability companies that are providers of services under the Medicare and Medicaid programs, and their respective partners and members, are subject to the anti-kickback statute. A number of the relationships that we have established with physicians and other healthcare providers do not fit within any of the statutory exceptions or safe harbor regulations issued by the Office of the Inspector General. All of the 219 surgical facilities in which we hold an ownership interest are owned by partnerships or limited liability companies, and 217 include as partners or members physicians who perform surgical or other procedures at the facilities. Because physician investors in our surgical facilities are in a position to generate referrals to the facilities, the distribution of available cash to those investors could come under scrutiny under the anti-kickback statute.

On November 19, 1999, the OIG promulgated regulations setting forth certain safe harbors under the anti-kickback statute, including a safe harbor applicable to surgery centers. The surgery center safe harbor generally protects ownership or investment interests in a center by physicians who are in a position to refer patients directly to the center and perform procedures at the center on referred patients, if certain conditions are met. More specifically, the surgery center safe harbor protects any payment that is a return on an ownership or investment interest to an investor if certain standards are met in one of four categories of ambulatory surgery centers (1) surgeon-owned surgery centers, (2) single-specialty surgery centers, (3) multi-specialty surgery centers, and (4) hospital/physician surgery centers.

For multi-specialty ambulatory surgery centers, for example, if all of the investors are (i) physicians who are in a position to refer patients directly to the entity and perform procedures on such referred patients, (ii) group practices composed exclusively of such physicians, or (iii) investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors and are not in a position to make or influence referrals directly to the entity or any of its investors, the following standards must be met:

(1) the terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity;

(2) at least one-third of each physician investor's medical practice income from all sources for the previous fiscal year or twelve-month period must be derived from performing outpatient procedures that require an ambulatory surgery center or specialty hospital setting in accordance with Medicare reimbursement rules;

(3) at least one third of the Medicare-eligible outpatient surgery procedures performed by each physician investor for the previous fiscal year or previous twelve-month period must be performed at the ambulatory surgery center in which the investment is made;

(4) the entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest;

(5) the amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor;

(6) all ancillary services for federal healthcare program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other federal healthcare programs; and

(7) the entity and any physician investors must treat patients receiving medical benefits or assistance under any federal healthcare program in a nondiscriminatory manner.

Similar standards apply to each of the remaining three categories of ambulatory surgery centers set forth in the regulations. In particular, each of the four categories includes the requirement that no ownership interests be held by a non-physician or non-hospital investor if that investor is (a) employed by the center or another investor, (b) in a position to provide items or services to the center or any of its other investors, or (c) in a position to make or influence referrals directly or indirectly to the center or any of its investors.

Because one of our subsidiaries is an investor in each partnership or limited liability company that owns one of our ambulatory surgery centers, and since this subsidiary provides management and other services to the surgery center, our arrangements with physician investors do not fit within the specific terms of the ambulatory surgery center safe harbor or any other safe harbor. We cannot assure you that the OIG would view our activities favorably even though we strive to achieve compliance with the remaining elements of the safe harbor.

In addition, although we typically contractually require that each physician-investor utilize the ASC as an extension of his or her practice, i.e. that such physician-investor meet the quantitative requirements of the surgery center safe harbor, because we do not control the medical practices of our physician investors or control where they perform surgical procedures, it is possible that the quantitative tests described above will not be met, or that other conditions of the surgery center safe harbor will not be met. Accordingly, while the surgery center safe harbor is helpful in establishing that a physician's investment in a surgery center should be considered an extension of the physician's practice and not as a prohibited financial relationship, we can give no assurances that these ownership interests will not be challenged under the anti-kickback statute. In an effort to monitor our compliance with the safe harbor's extension of practice requirement, we have implemented an attestation

process, which tracks physicians' annual extension of practice certification. While this process provides support for physician compliance with the safe harbor's quantitative tests, we can give no assurance of such compliance. However, we believe that our arrangements involving physician ownership interests in our ambulatory surgery centers do not fall within the activities prohibited by the anti-kickback statute.

With regard to our hospitals, the OIG has not adopted any safe harbor regulations under the anti-kickback statute for physician investments in hospitals. All but one of our hospitals is held in partnership with physicians who are in a position to refer patients to the hospital. There can be no assurances that these relationships will not be found to violate the anti-kickback statute or that there will not be regulatory or legislative changes that prohibit physician ownership of hospitals.

While several federal court decisions have aggressively applied the restrictions of the anti-kickback statute, they provide little guidance regarding the application of the anti-kickback statute to our partnerships and limited liability companies. We believe that our operations do not violate the anti-kickback statute. However, a federal agency charged with enforcement of the anti-kickback statute might assert a contrary position. Further, new federal laws, or new interpretations of existing laws, might adversely affect relationships we have established with physicians or other healthcare providers or result in the imposition of penalties on us or some of our facilities. Even the assertion of a violation could have a material adverse effect upon us.

In addition, the Medicare Patient and Program Protection Act of 1987, as amended by the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), and the Balanced Budget Act of 1997, impose civil monetary penalties and exclusion from state and federal healthcare programs on providers who commit violations of the Medicare fraud and abuse laws. Pursuant to the enactment of HIPAA, as of June 1, 1997, the Secretary of the U.S. Department of Health and Human Services may, and in some cases must, exclude individuals and entities that the Secretary determines have "committed an act" in violation of the Medicare fraud and abuse laws or improperly filed claims in violation of the Medicare fraud and abuse laws from participating in any federal healthcare program, HIPAA also expanded the Secretary's authority to exclude a person involved in fraudulent activity from participating in a program providing health benefits, whether directly or indirectly, in whole or in part, by the U.S. government. Additionally, under HIPAA, individuals who hold a direct or indirect ownership or controlling interest in an entity that is found to violate the Medicare fraud and abuse laws may also be excluded from Medicare and Medicaid and other federal and state healthcare programs if the individual knew or should have known, or acted with deliberate ignorance or reckless disregard of, the truth or falsity of the information of the activity leading to the conviction or exclusion of the entity, or where the individual is an officer or managing employee of such entity. This standard does not require that specific intent to defraud be proven by the OIG; however, the OIG will apply a series of factors enumerated in a guidance document issued in 2010 to determine whether exclusion is warranted. Under HIPAA it is also a crime to defraud any commercial healthcare benefit program.

On October 3, 2014, the OIG issued a proposed rule that would make amendments to the anti-kickback safe harbors and the civil monetary penalty ("CMP") regulations. Among other changes, the proposed rule would create new safe harbors for certain waivers of cost-sharing obligations by pharmacies and government-owned emergency ambulance services, and would codify certain statutory exceptions to the definition of "remuneration" under the CMP law. The proposed changes do not materially impact the analysis above regarding our risk of liability under the anti-kickback statute or CMP law.

Federal Physician Self-Referral Law

The Stark Law prohibits any physician from referring patients to any entity for the furnishing of certain "designated health services" otherwise payable by Medicare or Medicaid, if the physician or an immediate family member has a financial relationship such as an ownership interest or compensation arrangement with the entity that furnishes services to Medicare beneficiaries, unless an exception applies. Persons who violate the Stark Law are subject to potential civil money penalties of up to $15,000 for each bill or claim submitted in violation of the

Stark Law and up to $100,000 for each "circumvention scheme" they are found to have entered into, and potential exclusion from the Medicare and Medicaid programs. In addition, the Stark Law requires the denial (or, refund, as the case may be) of any Medicare and Medicaid payments received for designated health services that result from a prohibited referral.

The list of designated health services under the Stark Law does not include ambulatory surgery services as such. However, some of the ten types of designated health services are among the types of services furnished by our ambulatory surgery centers. The Department of Health and Human Services, acting through CMS, has promulgated regulations implementing the Stark Law. These regulations exclude health services provided by an ambulatory surgery center from the definition of "designated health services" if the services are included in the surgery center's composite Medicare payment rate. Therefore, the Stark Law's self-referral prohibition generally does not apply to health services provided by an ambulatory surgery center. However, if the ambulatory surgery center is separately billing Medicare for designated health services that are not covered under the ambulatory surgery center's composite Medicare payment rate, or if either the ambulatory surgery center or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ambulatory surgery center service, the Stark Law's self-referral prohibition would apply and such services could implicate the Stark Law. We believe that our operations do not violate the Stark Law, as currently interpreted. However, it is possible that CMS will further address the exception relating to services provided by an ambulatory surgery center in the future. Therefore, we cannot assure you that future regulatory changes will not result in our ambulatory surgery centers becoming subject to the Stark Law's self-referral prohibition.

Sixteen of our facilities are hospitals rather than ambulatory surgery centers, and physicians invest directly in fifteen of our sixteen hospitals. We believe that the physician investments in our hospitals fall within the whole hospital exception and are therefore permitted under the Stark Law. The whole hospital exception applies to physician ownership of a hospital, provided such ownership is in the whole hospital and the physician is authorized to perform services at the hospital. Physician investments in our facilities licensed as hospitals meet this requirement. However, changes to the whole hospital exception have been the subject of recent regulatory action and legislation. Changes in the Acts include:

- a prohibition on hospitals from having any physician ownership unless the hospital already had physician ownership and a Medicare provider agreement in effect as of December 31, 2010;
- a limitation on the maximum aggregate percentage of total physician ownership in the hospital to the aggregate percentage of physician ownership as of March 23, 2010;
- a prohibition on expanding the aggregate number of beds, operating rooms, and procedure rooms for which the hospital is licensed as of March 23, 2010, unless the hospital obtains an exception from the Secretary of the Department of Health and Human Services;
- a requirement that return on investment be proportionate to the investment by each investor;
- restrictions on preferential treatment of physician versus non-physician investors;
- a requirement for written disclosures of physician ownership interests to the hospital's patients and on the hospital's website and in any advertising, along with annual reports to the government detailing such interests;
- a prohibition on the hospital or other investors from providing financing to physician investors;
- a requirement that any hospital that does not have 24/7 physician coverage inform patients of this fact and receive signed acknowledgement from the patients of the disclosure; and
- a prohibition on "grandfathered" status for any physician owned hospital that converted from an ambulatory surgery center to a hospital on or after March 23, 2010 (of which we have none).

We cannot predict whether other proposed amendments to the whole hospital exception will be included in any future legislation or if Congress will adopt any similar provisions that would prohibit or otherwise restrict physicians from holding ownership interests in hospitals. The Acts could have an adverse effect on our financial condition and results of operations. See "Risk Factors — Healthcare Reform has restricted our ability to operate our surgical hospitals."

In addition to the physician ownership in our surgical facilities, we have other financial relationships with potential referral sources that potentially could be scrutinized under the fraud and abuse laws. We have entered into personal service agreements, such as medical director agreements, with physicians at our hospitals and ASCs. We believe that our agreements with referral sources satisfy the requirements of the applicable exceptions to the fraud and abuse laws and we have implemented formal compliance programs designed to safeguard against overbilling. However, we cannot assure you that the Office of the Inspector General would find our compliance programs to be adequate or that our agreements with referral sources would be found to comply with the fraud and abuse laws.

False and Other Improper Claims

The federal government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs. Claims filed with private insurers can also lead to criminal and civil penalties, including, but not limited to, penalties relating to violations of federal mail and wire fraud statutes. The government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances. For example, the government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The government has also taken the position that claiming payment for low-quality services is a violation of these statutes if the claimant should have known that the care was substandard.

Over the past several years, the government has accused an increasing number of healthcare providers of violating the federal False Claims Act. The False Claims Act prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the U.S. government for payment. The statute defines "knowingly" to include not only actual knowledge of a claim's falsity, but also reckless disregard for or intentional ignorance of the truth or falsity of a claim. Because our facilities perform hundreds of similar procedures a year for which they are paid by Medicare, and there is a relatively long statute of limitations (of up to ten years), a billing error or cost reporting error could result in significant penalties under the False Claims Act. Additionally, anti-kickback statute or Stark Law claims can be "bootstrapped" to claims under the False Claims Act on the theory that, when a provider submits a claim to a federal healthcare program, the claim includes an explicit or implicit certification that the provider is in compliance with the Medicare Act, which would require compliance with other laws, including the anti-kickback statute and the Stark Law. As a result of this "bootstrap" theory, the U.S. government can collect additional civil penalties under the False Claims Act for claims that have been "tainted" by the anti-kickback or Stark Law violation. In addition, civil penalties may be imposed by the Office of the Inspector General of the U.S. Department of Health and Human Services and a provider can be found liable for violating the False Claims Act for the failure to report and return an overpayment within 60 days of identifying the overpayment or, in certain circumstances, by the date a corresponding cost report is due, whichever is later.

Under the "qui tam," or whistleblower, provisions of the False Claims Act, private parties may bring actions on behalf of the federal government. Such private parties, often referred to as relators, are entitled to share in the amounts recovered by the government through trial or settlement. Both direct enforcement activity by the government and whistleblower lawsuits have increased significantly in recent years and have increased the risk that a healthcare company, like us, will have to defend a false claims action, pay fines or face exclusion from the Medicare and Medicaid programs as a result of an investigation resulting from a whistleblower complaint. Although we believe that our operations materially comply with both federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit, or may otherwise be challenged or scrutinized by

governmental authorities. Providers found liable for False Claims Act violations are subject to damages of up to three times the actual damage sustained by the government plus mandatory civil monetary penalties between $5,500 and $11,000 for each separate false claim. A determination that we have violated these laws could have a material adverse effect on us.

State Anti-Kickback and Physician Self-Referral Laws

Many states, including those in which we do or expect to do business, have laws that prohibit payment of kickbacks or other remuneration in return for the referral of patients. Some of these laws apply only to services reimbursable under state Medicaid programs. However, a number of these laws apply to all healthcare services in the state, regardless of the source of payment for the service. Based on court and administrative interpretations of the federal anti-kickback statute, we believe that the federal anti-kickback statute prohibits payments only if they are intended to induce referrals. However, the laws in most states regarding kickbacks have been subjected to more limited judicial and regulatory interpretation than federal law. Therefore, we can give you no assurances that our activities will be found to be in compliance with these laws. Noncompliance with these laws could subject us to penalties and sanctions and have a material adverse effect on us.

A number of states, including those in which we do or expect to do business, have enacted physician self-referral laws that are similar in purpose to the Stark Law but which impose different restrictions. Some states, for example, only prohibit referrals when the physician's financial relationship with a healthcare provider is based upon an investment interest. Other state laws apply only to a limited number of designated health services. Some states do not prohibit referrals, but require that a patient be informed of the financial relationship before the referral is made. We believe that our operations are in material compliance with the physician self-referral laws of the states in which our facilities are located.

Health Information Security and Privacy Practices

We are subject to HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), which was enacted as part of the American Recovery and Reinvestment Act of 2009 ("ARRA"). The regulations promulgated under HIPAA contain, among other measures, provisions that require many organizations, including us, to employ systems and procedures designed to protect the privacy and security of each patient's individual healthcare information. Among the standards that the Department of Health and Human Services has adopted pursuant to HIPAA are standards for the following:

- electronic transactions and code sets;
- unique identifiers for providers, employers, health plans and individuals;
- security and electronic signatures;
- privacy; and
- enforcement.

In August 2000, the Department of Health and Human Services finalized the transaction standards, with which we are in material compliance. The transaction standards require us to use standard code sets established by the rule when transmitting health information in connection with some transactions, including health claims and health payment and remittance advices.

The Department of Health and Human Services has also published a rule establishing standards for the privacy of individually identifiable health information, with which we are in material compliance. These privacy standards apply to all health plans, all healthcare clearinghouses and many healthcare providers, including healthcare providers that transmit health information in an electronic form in connection with certain standard transactions. We are a covered entity under the final rule. The privacy standards protect individually identifiable health information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally. These standards not only require our compliance with rules governing the use and disclosure of

protected health information, but they also require us to impose those rules, by contract, on any business associate to whom such information is disclosed, and, as of a final rule promulgated by the Department of Health and Human Services on January 25, 2013, by our business associates on any subcontractor to which such information is disclosed. Under the January 25, 2013, final rule, we were required to conform all of our contracts with business associates to certain established standards by September 23, 2014. The rule further requires certain revisions to our notices of privacy practices, redistribution of these policies to our patients, and for us to provide our patients with access to an electronic copy of their health records, upon request. A violation of the privacy standards could result in civil money penalties (which amounts are described below) and the federal rules also provide for criminal penalties of up to $50,000 and one year in prison for knowingly and improperly obtaining or disclosing protected health information, up to $100,000 and five years in prison for obtaining protected health information under false pretenses, and up to $250,000 and ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm.

Finally, the Department of Health and Human Services has also issued a rule establishing, in part, standards for the security of health information by health plans, healthcare clearinghouses and healthcare providers that maintain or transmit any health information in electronic form, regardless of format. We are an affected entity under the rule. These security standards require affected entities to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure integrity, confidentiality and the availability of the information. The security standards were designed to protect the health information against reasonably anticipated threats or hazards to the security or integrity of the information and to protect the information against unauthorized use or disclosure. Although the security standards do not reference or advocate a specific technology, and affected entities have the flexibility to choose their own technical solutions, the security standards required us to implement significant systems and protocols. We believe that we are in material compliance with these regulations.

Signed into law on February 17, 2009, the HITECH Act broadened the scope of the HIPAA privacy and security regulations. Among other things, the HITECH Act extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations. Under the HITECH Act, the U.S. Department of Health and Human Services is required to conduct periodic compliance audits of covered entities and their business associates. Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and the HITECH Act has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. The HITECH Act increased the amount of civil penalties, with penalties now ranging up to $50,000 per violation for a maximum civil penalty of $1,500,000 in a calendar year for violations of the same requirement. Under the final rule promulgated by the Department of Health and Human Services on January 25, 2013, civil monetary penalties may not be imposed for violations where the covered entity did not know or, after exercising reasonable diligence, could not have known that the violation had occurred, if the covered entity corrects the violation within 30 days. In addition, the HITECH Act authorized state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

In addition to HIPAA, many states have enacted their own security and privacy provisions concerning a patient's health information. These state privacy provisions will control whenever they provide more stringent privacy protections than HIPAA. Therefore, a healthcare facility could be required to meet both federal and state privacy provisions if it is located in a state with strict privacy protections.

Adoption of Electronic Health Records

ARRA also includes provisions designed to increase the use of Electronic Health Records ("EHR") by both physicians and hospitals. Beginning with 2011 and extending through 2016, eligible hospitals may receive reimbursement incentives based upon successfully demonstrating "meaningful use" of certified EHR technology.

Beginning in 2015, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to reductions in reimbursements. On July 13, 2010, CMS released final meaningful use regulations and on August 23, 2012, CMS released final rules on the Stage 2 meaningful use criteria. On September 4, 2014, CMS issued a final rule that, among other changes, grants providers flexibility to comply with the meaningful use requirements in 2014, and delays the January 1, 2016 deadline for the implementation of Stage 3 meaningful use requirements for the first cohort of adopters to January 1, 2017. We have implemented EHR at our hospitals and, with the exception of one hospital, complied with the EHR meaningful use requirements to date. As a result, 15 of the 16 hospitals we operate received cash payments of approximately $3.4 million and $7.2 million in 2014 and 2013, respectively, and are eligible to receive additional amounts in 2015 and 2016 if we meet meaningful use requirements in effect for those years. Implementation of EHR may result in additional costs in the future to comply with any changes in the meaningful use criteria that may be established in the future by HHS. Some or all of any additional costs may not be offset by the reimbursement incentives we will receive.

Audits

Our facilities will be subject to federal audits to validate the accuracy of Medicare and Medicaid program submitted claims. If these audits identify overpayments, we could be required to pay a substantial rebate of prior years' payments, including EHR incentives, subject to various administrative appeal rights. The federal government contracts with third-party recovery audit contractors ("RACs") to identify overpayment and underpayments for services through post-payment reviews of Medicare providers and suppliers. The Acts expand the RAC program's scope to include managed Medicare and to include Medicaid claims by requiring all states to establish programs to contract with RACs by December 31, 2010. In addition, the federal government employs Medicaid integrity contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. The Acts increase federal funding for the MIC program for federal fiscal year 2011 and later years. Similarly, Medicare zone program integrity contractors ("ZPICs") target claims for potential fraud and abuse. Additionally, Medicare administrative contractors ("MACs") must ensure they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. However, potential liability from future federal or state audits could ultimately exceed established reserves, and any excess could potentially be substantial.

Corporate Practice of Medicine

Several states have laws and/or regulations that prohibit corporations and other entities from employing physicians and practicing medicine for a profit or that prohibit certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes and/or regulations vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We do not expect these state corporate practice of medicine prescriptions to significantly affect our operations. Many states also have laws and regulations which prohibit payments for referral of patients and fee-splitting with physicians.

EMTALA

All of our hospitals in the United States are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every individual who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer an individual or if the hospital delays appropriate treatment in order to first inquire about the individual's

ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured individual, the individual's family or a medical facility that suffers a financial loss as a direct result of a hospital's violation of the law can bring a civil suit against the hospital. We believe our hospitals are in material compliance with EMTALA.

Regulatory Compliance Program

It is our policy to conduct our business with integrity and in compliance with the law. We have in place and continue to enhance a company-wide compliance program that focuses on regulatory compliance including billing, reimbursement, cost reporting practices and contractual arrangements with referral sources.

Our regulatory compliance program is intended to maintain high standards of conduct applicable to the conduct of our business and that policies and procedures are implemented so that employees act in full compliance with all applicable laws, regulations and company policies. Under the regulatory compliance program, every employee receives legal compliance and ethics training upon hire and annually thereafter. In addition, we regularly monitor our ongoing compliance efforts and develop and implement policies and procedures designed to foster compliance with the law. The program also includes a mechanism for employees to report, without fear of retaliation, any suspected legal or ethical violations through our independent compliance hotline. In addition, we perform excluded parties background checks of employees upon hire, annually thereafter and as otherwise required by state law. We believe our compliance program is consistent with standard industry practices. However, we cannot provide any assurances that our compliance program will detect all violations of law or protect against qui tam suits or government enforcement actions.

Item 1A. *Risk Factors*

You should corefully read the risks and uncertainties described below ond the other informotion included in this report. Any of the following risks could materially and odversely offect our business, financial condition or results of operations. Additional risks ond uncertainties not currently known to us or those we currently view to be immaterial may also materially ond adversely affect our business, financiol condition or results of operations.

We depend on payments from third-party payors, including government healthcare programs. If these payments are reduced, our revenue will decrease.

We are dependent upon private and governmental third-party sources of payment for the services provided to patients in our surgery centers and surgical hospitals. The amount of payment a surgical facility receives for its services may be adversely affected by market and cost factors as well as other factors over which we have no control, including Medicare and Medicaid regulations and the cost containment and utilization decisions of third-party payors. Fixed fee schedules, capitation payment arrangements, exclusion from participation in or inability to reach agreement with managed care programs or other factors affecting payments for healthcare services over which we have no control could also cause a reduction in our revenues.

If we are unable to acquire and develop additional surgical facilities on favorable terms, are not successful in integrating operations of acquired surgical facilities, or are unable to manage growth, we may be unable to execute our acquisition and development strategy, which could limit our future growth.

Our strategy is to increase our revenues and earnings by continuing to acquire and develop additional surgical facilities, primarily in collaboration with our health system partners. Our efforts to execute our acquisition and development strategy may be affected by our ability to identify suitable candidates and negotiate and close acquisition and development transactions. We are currently evaluating potential acquisitions and development projects and expect to continue to evaluate acquisitions and development projects in the foreseeable future. The surgical facilities we develop typically incur losses in their early months of operation (more so in the case of surgical hospitals) and, until their case loads grow, they generally experience lower total revenues and operating margins than established surgical facilities, and we expect this trend to continue. Historically, most of our newly developed facilities have generated positive cash flow within the first 12 months of operations. We may not be successful in acquiring surgical facilities, developing surgical facilities or achieving satisfactory operating results at acquired or newly developed facilities. Further, the companies or assets we acquire in the future may not ultimately produce returns that justify our related investment. If we are not able to execute our acquisition and development strategy, our ability to increase revenues and earnings through future growth would be impaired.

If we are not successful in integrating newly acquired surgical facilities, we may not realize the potential benefits of such acquisitions. Likewise, if we are not able to integrate acquired facilities' operations and personnel with ours in a timely and efficient manner, then the potential benefits of the transaction may not be realized. Further, any delays or unexpected costs incurred in connection with integration could have a material adverse effect on our operations and earnings. In particular, if we experience the loss of key personnel or if the effort devoted to the integration of acquired facilities diverts significant management or other resources from other operational activities, our operations could be impaired.

We have acquired interests in or developed all of our surgical facilities since our inception. We expect to continue to expand our operations in the future. Our rapid growth has placed, and will continue to place, increased demands on our management, operational and financial information systems and other resources. Further expansion of our operations will require substantial financial resources and management attention. To accommodate our past and anticipated future growth, and to compete effectively, we will need to continue to improve our management, operational and financial information systems and to expand, train, manage and motivate our workforce. Our personnel, systems, procedures or controls may not be adequate to support our operations in the future. Further, focusing our financial resources and management attention on the expansion of

our operations may negatively impact our financial results. Any failure to improve our management, operational and financial information systems, or to expand, train, manage or motivate our workforce, could reduce or prevent our growth.

We depend on our partnerships with the physicians who use our facilities. Our ability to provide medical services at our facilities would be impaired and our revenues reduced if we are not able to maintain these partnerships.

Our business depends upon the efforts and success of the physicians who provide medical and surgical services at our facilities and the strength of our partnerships with these physicians. Our revenues would be reduced if we fail to actively manage, with our physicians, our facilities or if we lose a relationship with one or more key physicians or group of physicians or such physicians or groups reduce their use of our facilities. Any failure of these physicians to maintain the quality of medical care provided or to otherwise adhere to professional guidelines at our surgical facilities or any damage to the reputation of a key physician or group of physicians could also damage our reputation, subject us to liability and significantly reduce our revenues. In addition, although physicians who own interests in our facilities are generally subject to agreements restricting them from owning an interest in competitive facilities, we may not learn of, or be unsuccessful in preventing, our physician partners from acquiring interests in competitive facilities.

In addition, healthcare reform may contribute to increased physician employment with hospitals, which could weaken our relationships with these physicians. The creation of ACOs in the Acts may cause physicians to accept employment to become part of a network that includes an ACO. The Acts' focus on investing in infrastructure to increase efficiencies may further contribute to shifting physicians' practice patterns from private practice to employment with hospitals and ACOs. ACOs that achieve quality performance standards established by the Department of Health and Human Services will be eligible to share in a portion of the amounts saved by the Medicare program. Because an individual physician may view the costs associated with investing in technology and processes to increase efficiencies as too large to bear individually, the physician may turn to employment as a means to participate in the Medicare savings and the capital investments required by the Acts. Physicians who accept employment may be restricted from owning interests in or utilizing our facilities.

Changes in our payor or case mix could adversely affect our business.

In general, we receive higher reimbursement rates from commercial and workers' compensation payors than Medicare, Medicaid and other government-funded programs. A material shift in our payor mix toward government-sponsored programs, which could occur for reasons beyond our control, could cause a reduction in our revenues. We also receive higher reimbursement for certain types of cases, such as orthopedic cases, compared to other procedures. A material shift in our case mix toward a higher percentage of lower revenue cases, which could occur for reasons beyond our control, could cause a reduction in our revenues.

If we fail to effectively and timely implement electronic health record systems, our operations could be adversely affected.

As required by ARRA, the Secretary of HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use EHR technology. We have incurred and will continue to incur both capital costs and operating expenses in order to implement certified EHR technology and meet meaningful use requirements. Through December 31, 2014, we have incurred approximately $26.6 million of costs to develop and deploy our certified EHR technology and to meet meaningful use requirements as they are defined for 2014 and 2013, which resulted in our hospitals receiving $3.4 million and $7.2 million in incentive payments in 2014 and 2013, respectively. Our hospitals are eligible for decreasing incentive amounts in 2015 and 2016 provided we continue to meet meaningful use requirements. Because CMS can change those requirements, we may incur additional costs in the future to maintain our eligibility for incentive funding, and we will additionally incur ongoing expense to support and maintain our existing EHR software. The timing of expenditures will not correlate with the receipt of incentive payments and

the recognition of incentive income. If our eligible hospitals are unable to continue to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments. In addition, although the ARRA incentive payment program does not apply to surgery centers, we have not yet determined an EHR solution for our surgery center facilities. A requirement that surgery centers adopt and meaningfully use EHR technology or a penalty on physicians for failing to perform enough procedures at facilities with EHR could cause us to incur significant additional capital costs and operating expenses. As physicians become more integrated with EHR in their practices, we could incur additional capital costs and operating expenses in connection with implementing new technologies at our surgery centers.

All providers and health plans subject to HIPAA, including our facilities, will be required to transition from the International Statistical Classification of Diseases (ICD)-9 to the ICD-10 coding system by October 1, 2015. (The previous scheduled implementation date of October 1, 2014, was delayed pursuant to the Protecting Access to Medicare Act of 2014 (P.L. 113-93), which was signed into law on April 1, 2014.) ICD-10 greatly expands the number and detail of billing codes used for claims. This transition requires a significant investment in technology and software and training of staff. In addition to these costs, it is possible that our facilities could experience disruption or delays in payment due to implementation issues or technical or coding errors by us or health plans and their business partners. Although it is unknown at this time, the transition to ICD-10 could result in decreased reimbursement if the ICD-10 codes reclassify conditions to payment groupings reimbursed at lower levels than assigned under the previous system.

Our revenues may be reduced by changes in payment methods or rates under the Medicare or Medicaid programs.

The Department of Health and Human Services and the states in which we perform surgical procedures for Medicaid patients may revise the Medicare and Medicaid payment methods or rates in the future. Any such changes could have a negative impact on the reimbursements we receive for our surgical services from the Medicare program and the state Medicaid programs. In addition, the Acts' requirement that the Department of Health and Human Services develop a plan to implement a value-based purchasing program for ambulatory surgery centers may further impact Medicare reimbursement of ambulatory surgery centers or increase our operating costs in order to satisfy any future value-based standards that may be authorized and implemented. The Acts' creation of a bundled payment initiative, under which organizations enter into payment arrangements that include financial and performance accountability for episodes of care, may impact our Medicare and other payors' reimbursement as organizations develop, implement and accept this new reimbursement model. The ultimate impact of the changes in reimbursement will depend on a number of factors, including the procedure mix at our facilities, our ability to demonstrate our high quality of care, our potential participation with other organizations in new payment programs and our ability to realize an increased procedure volume.

Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our debt obligations.

We have a substantial amount of indebtedness. As of December 31, 2014, we had $1.5 billion of total indebtedness and a total indebtedness to total capitalization percentage ratio of 72%.

Our and our subsidiaries' high degree of leverage could have important consequences to you. For example, it:

- requires us and certain of our subsidiaries to dedicate a substantial portion of cash flow from operations to payments on indebtedness, reducing the availability of cash flow to fund working capital, capital expenditures, development activity, acquisitions and other general corporate purposes;
- increases vulnerability to adverse general economic or industry conditions;
- limits flexibility in planning for, or reacting to, changes in our business or the industry in which we operate;

- makes us and our subsidiaries more vulnerable to increases in interest rates, as borrowings under our amended senior secured credit facilities are at variable rates;
- limits our and our subsidiaries' ability to obtain additional financing in the future for working capital or other purposes, such as raising the funds necessary to repurchase our senior unsecured notes upon the occurrence of specified changes of control, or
- places us at a competitive disadvantage compared to our competitors that have less indebtedness.

Our significant indebtedness could limit our flexibility.

We are significantly leveraged and will continue to have significant indebtedness in the future. Our acquisition and development program requires substantial capital resources, estimated to range from $125.0 million to $150.0 million per year over the next three years, although the range could be exceeded if we identify attractive multi-facility acquisition opportunities. The operations of our existing surgical facilities also require ongoing capital expenditures. We believe that our cash on hand, cash flows from operations and available borrowings under our revolving credit facility will be sufficient to fund our acquisition and development activities in 2015, but if we identify favorable acquisition and development opportunities that require additional resources, we may be required to incur additional indebtedness in order to pursue these opportunities. However, we may be unable to obtain sufficient financing on terms satisfactory to us, or at all. In that event, our acquisition and development activities would have to be curtailed or eliminated and our financial results could be adversely affected.

Our debt agreements contain restrictions that limit our flexibility in operating our business.

The operating and financial restrictions and covenants in our debt instruments, including our senior secured credit facilities and the indenture governing our senior unsecured notes, may adversely affect our ability to finance our future operations or capital needs or engage in other business activities that may be in our interest. For example, our senior secured credit facility restricts, subject to certain exceptions, our and our subsidiaries' ability to, among other things:

- incur, assume or permit to exist additional indebtedness or guarantees;
- incur liens and engage in sale leaseback transactions;
- make loans, investments and other advances;
- declare dividends, make payments or redeem or repurchase capital stock;
- engage in mergers, acquisitions and other business combinations;
- prepay, redeem or repurchase certain indebtedness including the notes;
- amend or otherwise alter terms of certain subordinated indebtedness including the notes;
- enter into agreements limiting subsidiary distributions;
- sell assets;
- engage in certain transactions with affiliates;
- alter the business that we conduct; and
- issue and sell capital stock of subsidiaries.

The indenture governing our senior notes includes similar restrictions. Our amended senior secured credit facility also requires us to comply with a financial covenant with respect to the revolving credit facility that becomes more restrictive over time. Our and our subsidiaries' ability to comply with these covenants and ratios may be affected by events beyond our control. A breach of any covenant or required financial ratio could result in a default under the senior secured credit facilities. In the event of any default under the senior secured credit

facilities, the applicable lenders could elect to terminate borrowing commitments and declare all borrowings and accrued interest and fees to be due and payable, to require us to apply all available cash to repay these borrowings or to prevent us from making or permitting subsidiaries to make distributions or dividends, the proceeds of which are used by us to make debt service payments on our senior subordinated notes, any of which would be an event of default under the notes.

If we incur material liabilities as a result of acquiring surgical facilities, our operating results could be adversely affected.

Although we conduct extensive due diligence prior to the acquisition of surgical facilities and seek indemnification from prospective sellers covering unknown or contingent liabilities, we may acquire surgical facilities that have material liabilities for failure to comply with healthcare laws and regulations or other past activities. Although we maintain professional and general liability insurance, we do not currently maintain insurance specifically covering any unknown or contingent liabilities that may have occurred prior to the acquisition of surgical facilities. If we incur these liabilities and are not indemnified or insured for them, our operating results and financial condition could be adversely affected.

We depend on our relationships with health system partners. If we are not able to maintain our relationships with these health system partners, or enter into new relationships, we may be unable to implement our business strategies successfully.

Our business depends in part upon the efforts and success of our health system partners and the strength of our relationships with those health systems. Our business could be adversely affected by any damage to those health systems' reputations or to our relationships with them. We may not be able to maintain our existing agreements on terms and conditions favorable to us or enter into relationships with additional health systems. Our relationships with health systems and the joint venture agreements that represent these relationships are structured to comply with current revenue rulings published by the Internal Revenue Service as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with health system partners. If we are unable to maintain our existing arrangements on terms favorable to us or enter into relationships with additional health system partners, we may be unable to implement our business strategies successfully.

If we and our health system partners are unable to successfully negotiate contracts and maintain satisfactory relationships and renew existing contracts on favorable terms with managed care organizations or other third-party payors, our revenues may decrease.

Our competitive position has been, and will continue to be, affected by initiatives undertaken during the past several years by major purchasers of healthcare services, including federal and state governments, insurance companies and employers, to revise payment methods and monitor healthcare expenditures in an effort to contain healthcare costs. As a result of these initiatives, managed care companies such as health maintenance and preferred provider organizations, which offer prepaid and discounted medical service packages, represent a growing segment of healthcare payors, the effect of which has been to reduce the growth of healthcare facility margins and revenue. We have undertaken initiatives to favorably position our facilities to respond to these changing payment methodologies and cost containment efforts, but the ultimate success of our initiatives is unknown at this time.

As an increasing percentage of patients become subject to healthcare coverage arrangements with managed care payors, we believe that our success will continue to depend upon our and our health system partners' ability to negotiate favorable contracts and payment arrangements on behalf of our facilities with managed care organizations, employer groups and other private third-party payors. We have structured our ventures with health system partners in a manner we believe to be consistent with applicable regulatory requirements. If applicable regulatory requirements were interpreted to require changes to our existing arrangements, or if we are unable to enter into these arrangements on satisfactory terms in the future, we could be adversely affected. Many of these

payors already have existing provider structures in place and may not be able or willing to change their provider networks. We could also experience a material adverse effect to our operating results and financial condition as a result of the termination of existing third-party payor contracts. In addition, in recent years many payors and healthcare plans have increased plan participants' co-payments, co-insurance and deductibles. Patient volumes could be negatively impacted if this trend continues.

Our surgical facilities face competition for patients from other healthcare providers.

The healthcare business is highly competitive, and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other facilities in the local communities served by our facilities provide services similar to those offered by our surgery centers and surgical hospitals. In addition, the number of freestanding surgical hospitals and surgery centers in the geographic areas in which we operate has increased significantly, and many of these facilities operate under different reimbursement models than we have traditionally seen. As a result, most of our surgery centers and surgical hospitals operate in a highly competitive environment. Some of the hospitals that compete with our facilities are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Our surgery centers and surgical hospitals are facing increasing competition from unaffiliated physician-owned surgery centers and surgical hospitals for market share in high margin services and for quality physicians and personnel. If our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our surgery centers and surgical hospitals, we may experience an overall decline in patient volume.

Financial pressures on patients may adversely impact our business.

Even as the U.S. economy shows signs of sustained, if modest, growth, many individuals throughout the country continue to experience difficult financial conditions. Burdened by economic constraints and higher patient deductibles, patients have delayed or canceled non-emergency surgical procedures in recent years. Although we have taken steps to minimize the impact of these conditions, it is difficult to predict the degree to which our business will continue to be impacted by such conditions or the course of the economy in the future.

The Supreme Court's 2014 decision to hear the case of *King v. Burwell*—a Fourth Circuit decision upholding an IRS rule extending tax credits to individuals purchasing health insurance under the Acts through federally established exchanges—poses an additional element of uncertainty and risk. If the IRS rule is struck down, millions of individuals in the 36 states with federal exchanges would be ineligible for federal health insurance subsidies, and would likely lose insurance coverage entirely absent further action by Congress or the states. Apart from the political upheaval and resulting uncertainty regarding the future implementation of the Acts, such a result could adversely affect our business by exacerbating the financial pressures on patients in these states, leading them to further delay or cancel non-emergency surgical procedures.

Our surgical facilities may be negatively impacted by weather and other factors beyond our control.

The results of operations of our surgical facilities may be adversely impacted by adverse weather conditions, including hurricanes, or other factors beyond our control that cause disruption of patient scheduling, displacement of our patients, employees and physician partners and force certain of our surgical facilities to close temporarily. In certain markets, we have a large concentration of surgical facilities that could be simultaneously affected by adverse weather conditions or events.

Shortages or quality control issues with medical supplies could disrupt our operations and negatively impact our profitability.

We depend on our ability to obtain medical supplies from suppliers on a timely basis. If we are unable to obtain such necessary supplies for a period of time, we would be unable to perform certain surgeries. As a result, we could suffer operational disruptions, increased costs and reductions in profitability. Medical supplies may also

be subject to supplier quality control incidents. Significant quality control issues by producers or vendors have occurred in the past and may occur again in the future, for reasons beyond our control. Such issues could negatively impact our operations regardless of whether they were caused by us.

Efforts to regulate the construction, acquisition or expansion of healthcare facilities could prevent us from acquiring additional surgical facilities, renovating our existing facilities or expanding the breadth of services we offer.

Many states in the United States require prior approval for the construction, acquisition or expansion of healthcare facilities or expansion of the services they offer. When considering whether to approve such projects, these states take into account the need for additional or expanded healthcare facilities or services. In a number of states in which we operate, we are required to obtain certificates of need for capital expenditures exceeding a prescribed amount, changes in bed capacity or services offered and under various other circumstances. Other states in which we now or may in the future operate may adopt certificate of need legislation or regulatory provisions. Our costs of obtaining a certificate of need have ranged up to $500,000. Although we have not previously been denied a certificate of need, we may not be able to obtain the certificates of need or other required approvals for additional or expanded facilities or services in the future. In addition, at the time we acquire a facility, we may agree to replace or expand the acquired facility. If we are unable to obtain the required approvals, we may not be able to acquire additional surgery centers or surgical hospitals, expand the healthcare services provided at these facilities or replace or expand acquired facilities.

If any of our existing healthcare facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

The construction and operation of healthcare facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards.

All of our facilities are deemed certified, meaning that they are accredited, properly licensed under the relevant state laws and regulations and certified under the Medicare program or are in the process of applying for such accreditation, licensing or certification. The effect of maintaining certified facilities is to allow such facilities to participate in the Medicare and Medicaid programs. We believe that all of our healthcare facilities are in material compliance with applicable federal, state, local and other relevant regulations and standards. However, should any of our healthcare facilities lose their deemed certified status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and our business could be materially adversely affected.

Failure to comply with federal and state statutes and regulations relating to patient privacy and electronic data security could negatively impact our financial results.

There are currently numerous federal and state statutes and regulations that address patient privacy concerns and federal standards that address the maintenance of the security of electronically maintained or transmitted electronic health information and the format of transmission of such information in common healthcare financing information exchanges. These provisions are intended to enhance patient privacy and the effectiveness and efficiency of healthcare claims and payment transactions. In particular, the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 required us to implement new systems and to adopt business procedures for transmitting healthcare information and for protecting the privacy and security of individually identifiable information.

We believe that we are in material compliance with existing state and federal regulations relating to patient privacy, security and with respect to the format for electronic healthcare transactions. However, if we fail to comply with the federal privacy, security and transactions and code sets regulations, we could incur significant civil and criminal penalties. Failure to comply with state laws related to privacy could, in some cases, also result in civil fines and criminal penalties.

Our operations could be impaired by a failure of our information systems.

An information system failure that causes an interruption in service or availability of our information systems could adversely affect operations or delay the collection of revenues. We have implemented multiple layers of security measures through technology, processes, and our people; utilize current security technologies; and our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, threats from malicious persons and groups, new vulnerabilities, and advanced new attacks against information technology systems create risk of cyber security incidents that could impact availability of systems. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation.

If we fail to comply with applicable laws and regulations, we could suffer penalties or be required to make significant changes to our operations.

We are subject to many laws and regulations at the federal, state and local government levels in the jurisdictions in which we operate. These laws and regulations require that our healthcare facilities meet various licensing, certification and other requirements, including those relating to:

- physician ownership of our facilities;
- the adequacy of medical care, equipment, personnel, operating policies and procedures;
- building codes;
- licensure, certification and accreditation;
- billing for services;
- handling of medication;
- maintenance and protection of records; and
- environmental protection.

We believe that we are in material compliance with applicable laws and regulations. However, if we fail or have failed to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in Medicare, Medicaid and other government sponsored healthcare programs. A number of initiatives have been proposed during the past several years to reform various aspects of the healthcare system in the United States. In the future, different interpretations or enforcement of existing or new laws and regulations could subject our current practices to allegations of impropriety or illegality, or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Current or future legislative initiatives or government regulation may have a material adverse effect on our operations or reduce the demand for our services.

In pursuing our growth strategy, we may expand our presence into new geographic markets. In entering a new geographic market, we will be required to comply with laws and regulations of jurisdictions that may differ from those applicable to our current operations. If we are unable to comply with these legal requirements in a cost-effective manner, we may be unable to enter new geographic markets.

If a federal or state agency asserts a different position or enacts new laws or regulations regarding illegal remuneration under the Medicare or Medicaid programs, we may be subject to civil and criminal penalties, experience a significant reduction in our revenues or be excluded from participation in the Medicare and Medicaid programs.

The federal anti-kickback statute prohibits the offer, payment, solicitation or receipt of any form of remuneration in return for referrals for items or services payable by Medicare, Medicaid, or any other federally funded healthcare program. Additionally, the anti-kickback statute prohibits any form of remuneration in return for purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of items or services payable by Medicare, Medicaid or any other federally funded healthcare program. The anti-kickback statute is very broad in scope and many of its provisions have not been uniformly or definitively interpreted by existing case law or regulations. Moreover, several federal courts have held that the anti-kickback statute can be violated if only one purpose (not necessarily the primary purpose) of a transaction is to induce or reward a referral of business, notwithstanding other legitimate purposes. Violations of the anti-kickback statute may result in substantial civil or criminal penalties, including up to five years imprisonment and criminal fines of up to $25,000 and civil penalties of up to $50,000 for each violation, plus three times the remuneration involved or the amount claimed and exclusion from participation in all federally funded healthcare programs. An exclusion, if applied to our surgery centers or surgical hospitals, could result in significant reductions in our revenues, which could have a material adverse effect on our business.

In July 1991, the Department of Health and Human Services issued final regulations defining various "safe harbors." Two of the safe harbors issued in 1991 apply to business arrangements similar to those used in connection with our surgery centers and surgical hospitals: the "investment interest" safe harbor and the "personal services and management contracts" safe harbor. However, the structure of the partnerships and limited liability companies operating our surgery centers and surgical hospitals, as well as our various business arrangements involving physician group practices, do not satisfy all of the requirements of either safe harbor.

On November 19, 1999, the Department of Health and Human Services promulgated final regulations creating additional safe harbor provisions, including a safe harbor that applies to physician ownership of or investment interests in surgery centers. The surgery center safe harbor protects four types of investment arrangements: (1) surgeon owned surgery centers; (2) single specialty surgery centers; (3) multi-specialty surgery centers; and (4) hospital/physician surgery centers. Each category has its own requirements with regard to what type of physician may be an investor in the surgery center. In addition to the physician investor, the categories permit an "unrelated" investor, who is a person or entity that is not in a position to provide items or services related to the surgery center or its investors. Our business arrangements with our surgical facilities typically consist of one of our subsidiaries being an investor in each partnership or limited liability company that owns the facility, in addition to providing management and other services to the facility. Therefore, our business arrangements with our surgery centers, surgical hospitals and physician groups do not qualify for "safe harbor" protection from government review or prosecution under the anti-kickback statute. When a transaction or relationship does not fit within a safe harbor, it does not mean that an anti-kickback violation has occurred; rather, it means that the facts and circumstances as well as the intent of the parties related to a specific transaction or relationship must be examined to determine whether or not any illegal conduct has occurred.

Although we believe that our business arrangements do not violate the anti-kickback statute, a government agency or a private party may assert a contrary position. Additionally, new federal or state laws may be enacted that would cause our relationships with the physician investors to become illegal or result in the imposition of penalties against us or our facilities. If any of our business arrangements with physician investors were deemed to violate the anti-kickback statute or similar laws, or if new federal or state laws were enacted rendering these arrangements illegal, our business could be adversely affected.

Also, most of the states in which we operate have adopted anti-kickback laws, many of which apply more broadly to all third-party payors, not just to federal or state healthcare programs. Many of the state laws do not have regulatory safe harbors comparable to the federal provisions and have only rarely been interpreted by the

courts or other governmental agencies. We believe that our business arrangements do not violate these state laws. Nonetheless, if our arrangements were found to violate any of these anti-kickback laws, we could be subject to significant civil and criminal penalties that could adversely affect our business.

If physician self-referral laws are interpreted differently or if other legislative restrictions are issued, we could incur significant sanctions and loss of reimbursement revenues.

The U.S. federal physician self-referral law, commonly referred to as the "Stark Law," prohibits a physician from making a referral for a "designated health service" to an entity to furnish an item or service payable under Medicare if the physician or a member of the physician's immediate family has a financial relationship with the entity such as an ownership interest or compensation arrangement, unless an exception applies. The list of designated health services under the Stark Law does not include ambulatory surgery services as such. However, some of the designated health services are among the types of services furnished by our facilities.

The Department of Health and Human Services, acting through the CMS, has promulgated regulations implementing the Stark Law. These regulations exclude health services provided by an ambulatory surgery center from the definition of "designated health services" if the services are included in the facility's composite Medicare payment rate. Therefore, the Stark Law's self-referral prohibition generally does not apply to health services provided by a surgery center. However, if the surgery center is separately billing Medicare for designated health services that are not covered under the surgery center's composite Medicare payment rate, or if either the surgery center or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ambulatory surgery center service, the Stark Law's self-referral prohibition would apply and such services could implicate the Stark Law. We believe that our operations do not violate the Stark Law, as currently interpreted.

In addition, we believe that physician ownership of surgery centers is not prohibited by similar self-referral statutes enacted at the state level. However, the Stark Law and similar state statutes are subject to different interpretations with respect to many important provisions. Violations of these self-referral laws may result in substantial civil or criminal penalties, including large civil monetary penalties and exclusion from participation in the Medicare and Medicaid programs. Exclusion of our surgery centers or surgical hospitals from these programs through future judicial or agency interpretation of existing laws or additional legislative restrictions on physician ownership or investments in healthcare entities could result in significant loss of reimbursement revenues.

We may be subject to actions for false and other improper claims.

Federal and state government agencies, as well as private payors, have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of the cost reporting and billing practices of healthcare organizations and their quality of care and financial relationships with referral sources. In addition, the Office of the Inspector General of the U.S. Department of Health and Human Services, and the U.S. Department of Justice have, from time to time, undertaken national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse.

The U.S. government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs and other federal and state healthcare programs. Claims filed with private insurers can also lead to criminal and civil penalties, including, but not limited to, penalties relating to violations of federal mail and wire fraud statutes, as well as penalties under the anti-fraud provisions of the HIPAA. The U.S. government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances. For example, the government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The government has also taken the position that claiming payment for low-quality services is a violation of these statutes if the claimant should have known that the care was substandard. The Fraud Enforcement and Recovery Act of 2009 ("FERA") further expanded the scope of the False Claims Act to create

liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government and FERA, along with statutory provisions found in the Acts, created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or, in certain cases, the date by which a corresponding cost report is due, whichever is later. Although we believe that our operations comply with both federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit or may otherwise be challenged or scrutinized by governmental authorities. A determination that we have violated these laws could have a material adverse effect on our financial condition or results of operations.

Companies within the healthcare industry continue to be the subject of federal and state audits and investigations, which increases the risk that we may become subject to investigations in the future.

Both federal and state government agencies, as well as private payors, have heightened and coordinated audits and administrative, civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare organizations. These investigations relate to a wide variety of topics, including the following:

- cost reporting and billing practices;
- quality of care;
- financial reporting;
- financial relationships with referral sources; and
- medical necessity of services provided.

In addition, the Office of the Inspector General of the Department of Health and Human Services and the Department of Justice have, from time to time, undertaken national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. In its 2013 Work Plan, the office of the Inspector General stated its intention to review the safety and quality of care for Medicare beneficiaries having surgeries and procedures in ambulatory surgery centers and hospital outpatient departments. We have not received any related audit letters to date. Moreover, another trend impacting healthcare providers is the increased use of the federal False Claims Act, particularly by individuals who bring actions under that law. Such "qui tam" or "whistleblower" actions allow private individuals to bring actions on behalf of the government alleging that a healthcare provider has defrauded the federal government. If the government intervenes and prevails in the action, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil monetary penalties of between $5,500 and $11,000 for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may pursue the action independently. Additionally, some states have adopted similar whistleblower and false claims provisions. Although companies in the healthcare industry have been, and may continue to be, subject to qui tam actions, we are unable to predict the impact of such actions on our business, financial position or results of operations.

If laws governing the corporate practice of medicine or fee-splitting change, we may be required to restructure some of our relationships which may result in significant costs to us and divert other resources.

The laws of various jurisdictions in which we operate or may operate in the future do not permit business corporations to practice medicine, exercise control over physicians who practice medicine or engage in various business practices, such as fee-splitting with physicians (i.e., sharing a percentage of professional fees). The interpretation and enforcement of these laws vary significantly from state to state. We are not required to obtain a license to practice medicine in any jurisdiction in which we own or operate a surgery center or surgical hospital because our facilities are not engaged in the practice of medicine. The physicians who utilize our facilities are individually licensed to practice medicine. In most instances, the physicians and physician group practices performing medical services at our facilities do not have investment or business relationships with us other than through the physicians' ownership interests in the partnerships or limited liability companies that own and operate our facilities and the service agreements we have with some of those physicians.

Through our OrthoLink subsidiary, we provide consulting and administrative services to a number of physicians and physician group practices affiliated with OrthoLink. Although we believe that our arrangements with these and other physicians and physician group practices comply with applicable laws, a government agency charged with enforcement of these laws, or a private party, might assert a contrary position. If our arrangements with these physicians and physician group practices were deemed to violate state corporate practice of medicine, fee-splitting or similar laws, or if new laws are enacted rendering our arrangements illegal, we may be required to restructure these arrangements, which may result in significant costs to us and divert other resources.

If regulations change, we may be obligated to purchase some or all of the ownership interests of the physicians affiliated with us.

Upon the occurrence of various fundamental regulatory changes, we could be obligated to purchase some or all of the ownership interests of the physicians affiliated with us in the partnerships or limited liability companies that own and operate our surgery centers and surgical hospitals. The regulatory changes that could create this obligation include changes that:

- make illegal the referral of Medicare or other patients to our surgical facilities by physicians affiliated with us;
- create the substantial likelihood that cash distributions from the limited partnerships or limited liability companies through which we operate our surgical facilities to physicians affiliated with us would be illegal; or
- make illegal the ownership by the physicians affiliated with us of interests in the partnerships or limited liability companies through which we own and operate our surgical facilities.

At this time, we are not aware of any regulatory amendments or proposed changes that would trigger this obligation. Typically, our partnership and limited liability company agreements allow us to use shares of our common stock as consideration for the purchase of a physician's ownership interest. The use of shares of our common stock for that purpose would dilute the ownership interests of our common stockholders. In the event that we are required to purchase all of the physicians' ownership interests and our common stock does not maintain a sufficient valuation, we could be required to use our cash resources for the acquisitions, the total cost of which we estimate to be up to approximately $610.9 million at December 31, 2014. The creation of these obligations and the possible termination of our affiliation with these physicians could have a material adverse effect on us.

Healthcare reform has restricted our ability to operate our surgical hospitals.

The Acts provide, among other things: (i) a prohibition on hospitals from having any physician ownership unless the hospital already had physician ownership and a Medicare provider agreement in effect on December 31, 2010; (ii) a limitation on the maximum percentage of total physician ownership in the hospital to the percentage of physician ownership as of March 23, 2010; (iii) a requirement for written disclosures of physician ownership interests, along with an annual report to the government detailing such ownership; and (iv) restrictions on the ability of a hospital subject to the whole hospital exception to add operating rooms, procedure rooms and beds.

Fifteen of our existing hospitals were grandfathered at the dates of enactment of the Acts, although they are largely prohibited from expanding their physical plants. Our sixteenth hospital does not have any physician ownership. If future legislation were to be enacted by Congress that prohibits physician referrals to hospitals in which the physicians own an interest, or that otherwise further limits physician ownership in existing facilities, our financial condition and results of operations could be materially adversely affected.

If we become subject to significant legal actions, we could be subject to substantial uninsured liabilities.

In recent years, physicians, surgery centers, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice or related legal theories. Many of these actions

involve large monetary claims and significant defense costs. In particular, since the majority of our hospitals maintain emergency departments, there is an increased risk of claims at these facilities because of the nature of the cases seen in the emergency departments. We do not employ any of the physicians who conduct surgical procedures at our facilities and the governing documents of each of our facilities require physicians who conduct surgical procedures at our facilities to maintain stated amounts of insurance. Additionally, to protect us from the cost of these claims, we maintain (through a captive insurance company) professional malpractice liability insurance and general liability insurance coverage in amounts and with deductibles that we believe to be appropriate for our operations. Although we have excess coverage beyond our captive, we are effectively self-insured up to the excess. If we become subject to claims, however, our insurance coverage may not cover all claims against us or continue to be available at adequate levels of insurance. If one or more successful claims against us were not covered by or exceeded the coverage of our insurance, we could be adversely affected.

If we are unable to effectively compete for physicians, strategic relationships, acquisitions and managed care contracts and implement and execute responses to competitive changes, our business could be adversely affected.

The healthcare business is highly competitive. We compete with other healthcare providers, primarily other surgery centers and hospitals, in recruiting physicians and contracting with managed care payors in each of our markets. There are major unaffiliated hospitals in each market in which we operate. These hospitals have established relationships with physicians and payors. In addition, other companies either are currently in the same or similar business of developing, acquiring and operating surgery centers and surgical hospitals or may decide to enter our business. Many of these other facilities compete with us for market share in high margin services and for quality physicians and personnel and operate under different reimbursement models than we have traditionally seen. We may also compete with some of these companies for entry into strategic relationships with health systems and healthcare professionals. If we are unable to identify and execute solutions to compete effectively with any of these entities, we may be unable to implement our business strategies successfully and our business could be adversely affected.

Because our senior management has been key to our growth and success, we may be adversely affected if we lose any member of our senior management.

We are highly dependent on our senior management, including William H. Wilcox, who is our chief executive officer and Brett P. Brodnax, who is our president and chief development officer. Although we have employment agreements with Mr. Wilcox and Mr. Brodnax and other senior managers, we do not maintain "key man" life insurance policies on any of our officers. Because our senior management has contributed greatly to our growth since inception, the loss of key management personnel or our inability to attract, retain and motivate sufficient numbers of qualified management or other personnel could have a material adverse effect on us.

The growth of patient receivables and a deterioration in the collectability of these accounts could adversely affect our results of operations.

The primary collection risks of our accounts receivable relate to patient receivables for which the primary insurance carrier has paid the amounts covered by the applicable agreement but patient responsibility amounts (deductibles and copayments) remain outstanding. The allowance for doubtful accounts relates primarily to amounts due directly from patients.

We provide for bad debts principally based upon the aging of accounts receivable and use specific identification to write-off amounts against our allowance for doubtful accounts, without differentiation between payor sources. Our allowance for doubtful accounts at December 31, 2014 and 2013, represented approximately 17% and 16% of our accounts receivable balance, respectively. Due to the difficulty in assessing future trends, we could be required to increase our provisions for doubtful accounts. A deterioration in the collectability of these accounts could adversely affect our collection of accounts receivable, cash flows and results of operations.

We may have a special legal responsibility to the holders of ownership interests in the entities through which we own surgical facilities, and that responsibility may prevent us from acting solely in our own best interests or the interests of our stockholders.

Our ownership interests in surgery centers and surgical hospitals generally are held through partnerships or limited liability companies. We typically maintain an interest in a partnership or limited liability company in which physicians or physician practice groups also hold interests. As general partner or manager of these entities, we may have a special responsibility, known as a fiduciary duty, to manage these entities in the best interests of the other owners. We also have a duty to operate our business for the benefit of our stockholders. As a result, we may encounter conflicts between our responsibility to the other owners and our responsibility to our stockholders. For example, we have entered into management agreements to provide management services to our facilities in exchange for a fee. Disputes may arise as to the nature of the services to be provided or the amount of the fee to be paid. In these cases, we are obligated to exercise reasonable, good faith judgment to resolve the disputes and may not be free to act solely in our own best interests. Disputes may also arise between us and our affiliated physicians with respect to a particular business decision or regarding the interpretation of the provisions of the applicable partnership or limited liability company agreement. If we are unable to resolve a dispute on terms favorable or satisfactory to us, our business may be adversely affected.

We do not have exclusive control over the distribution of revenues from some of our operating entities and may be unable to cause all or a portion of the revenues of these entities to be distributed.

All of the surgical facilities in which we have ownership interests are partnerships or limited liability companies in which we own, directly or indirectly, ownership interests. Our partnership, and limited liability company agreements, which are typically with the physicians who perform procedures at our surgical facilities, usually provide for the monthly or quarterly pro-rata cash distribution of net profits from operations, less amounts to satisfy obligations such as the entities' non-recourse debt and capitalized lease obligations, operating expenses and working capital. The creditors of each of these partnerships and limited liability companies are entitled to payment of the entities' obligations to them, when due and payable, before ordinary cash distributions or distributions in the event of liquidation, reorganization or insolvency may be made. We generally control the entities that function as the general partner of the partnerships or the managing member of the limited liability companies through which we conduct operations. However, we do not have exclusive control in some instances over the amount of net revenues distributed from some of our operating entities. If we are unable to cause sufficient revenues to be distributed from one or more of these entities, our relationships with the physicians who have an interest in these entities may be damaged and we could be adversely affected. We may not be able to resulve favorably any dispute regarding revenue distribution or other matters with a healthcare system with which we share control of one of these entities. Further, the failure to resolve a dispute with these healthcare systems could cause the entity we jointly control to be dissolved.

Welsh Carson controls us and may have conflicts of interest with us or you in the future.

An investor group led by Welsh Carson owns substantially all of the outstanding equity securities of our Parent, USPI Group Holdings, Inc. Welsh Carson controls a majority of the voting power of such outstanding equity securities and therefore ultimately controls all of our affairs and policies, including the election of our board of directors, the approval of certain actions such as amending our charter, commencing bankruptcy proceedings and taking certain corporate actions (including, without limitation, incurring debt, issuing stock, selling assets and engaging in mergers and acquisitions), and appointing members of our management. The interests of Welsh Carson could conflict with your interests.

Additionally, Welsh Carson is in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Welsh Carson may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. So long as investment funds associated with or designated by Welsh Carson continue to indirectly own a significant amount of our capital stock, even if such amount is less than 50% of our outstanding common stock on a fully-diluted basis, Welsh Carson will continue to be able to strongly influence or effectively control our decisions.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

The response to this item is included in Item 1.

Item 3. ***Legal Proceedings***

From time to time, we may be named as a party to legal claims and proceedings in the ordinary course of business. We are not aware of any claims or proceedings against us or our subsidiaries that might have a material adverse impact on us.

Item 4. ***Mine Safety Disclosures***

Not applicable.

PART II

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

We are wholly-owned by USPI Holdings, Inc., which is wholly-owned by USPI Group Holdings, Inc., both of which are privately owned corporations. There is no public trading market for our equity securities or those of USPI Holdings, Inc. or USPI Group Holdings, Inc. As of February 23, 2015, there were 238 holders of USPI Group Holdings, Inc. common stock.

Payment of dividends is restricted under our amended senior secured credit facility and the indenture governing our senior notes, except for limited circumstances. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Financing Activities — Dividend Payment." Any future determination to pay dividends will be at the discretion of our board of directors and will depend on our financial condition, results of operation, capital requirements, restrictions contained in current and future financing instruments and other factors that our board of directors deems relevant.

Item 6. *Selected Financial Data*

The selected consolidated statement of operations data set forth below for the years ended December 31, 2014, 2013, 2012, 2011 and 2010 and the consolidated balance sheet data at December 31, 2014, 2013, 2012, 2011, and 2010 are derived from our consolidated financial statements.

The historical results presented below (in thousands, except number of facilities) are not necessarily indicative of results to be expected for any future period. The comparability of the financial and other data included in the table is affected by our debt refinancing in April 2013 and 2012, the U.K. goodwill impairment in 2011 (now presented in discontinued operations), and various acquisitions completed during the years presented. In addition, the results of operations of subsidiaries sold by us, including the spin-off of our U.K. subsidiary in April 2012 have been reclassified to "discontinued operations" for all data presented in the table below except for the "consolidated balance sheet data." For a more detailed explanation of this financial data, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" and the consolidated financial statements and related notes included elsewhere in this report.

	Year Ended December 31, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012	Year Ended December 31, 2011	Year Ended December 31, 2010
Consolidated Statements of Operations Data:					
Total revenues	$ 640,824	$ 616,231	$ 540,235	$ 499,178	$ 473,949
Equity in earnings of unconsolidated affiliates	116,607	95,520	96,393	83,137	69,916
Operating expenses excluding depreciation and amortization	(461,651)	(420,722)	(367,439)	(327,479)	(326,762)
Depreciation and amortization	(26,004)	(27,238)	(23,955)	(21,177)	(22,493)
Operating income	269,776	263,791	245,234	233,659	194,610
Other income (expense):					
Interest income	1,287	1,359	676	516	742
Interest expense	(95,028)	(101,163)	(85,934)	(63,537)	(66,886)
Loss on early retirement of debt	—	(5,536)	(37,450)	—	—
Other, net	(68)	(2)	(613)	(73)	708
Income from continuing operations before income taxes	175,967	158,449	121,913	170,565	129,174
Income tax expense	(37,507)	(31,389)	(21,502)	(39,918)	(29,257)
Income from continuing operations	138,460	127,060	100,411	130,647	99,917
Earnings (loss) from discontinued operations, net of tax	(332)	—	3,073	(111,562)	2,736
Net income	138,128	127,060	103,484	19,085	102,653
Less: Net income attributable to noncontrolling interests	(77,081)	(78,782)	(72,693)	(69,929)	(60,560)
Net income (loss) attributable to USPI's common stockholder	$ 61,047	$ 48,278	$ 30,791	$ (50,844)	$ 42,093
Other Data:					
Number of facilities operated as of the end of period(a):					
Consolidated	63	65	64	59	54
Equity method	156	149	149	141	130
Management contract only	—	—	—	—	1
Total	219	214	213	200	185
Cash flows from operating activities	$ 211,558	$ 159,892	$ 180,313	$ 164,667	$ 148,318

	As of December 31,				
	2014	2013	2012	2011	2010
Consolidated Balance Sheet Data:					
Working capital (deficit)	$ (124,545)	$ (102,399)	$ (102,432)	$ (121,909)	$ (100,249)
Cash and cash equivalents	36,554	78,741	51,203	41,822	60,253
Total assets	2,583,857	2,480,684	2,360,749	2,393,498	2,372,739
Total debt	1,475,871	1,473,608	1,479,534	1,068,456	1,069,826
Noncontrolling interests — redeemable	195,059	166,578	153,399	106,668	81,668
Total equity	380,778	326,642	271,987	767,871	821,151

(a) Not derived from audited financial statements; excludes our former U.K. facilities.

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operation*

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with "Selected Financial Data" and our consolidated financial statements and related notes included elsewhere in this report.

Overview

We are an experienced and trusted partner in some of the nation's most successful surgical networks. We provide strategic solutions for physicians, physician networks, leading health systems and those paying for the cost of healthcare services, such as employers, insurance companies and government programs.

Our portfolio includes 219 short-stay surgical facilities in 27 states. In these facilities, which are licensed as either ambulatory surgery centers, specialty hospitals or hospitals, we serve almost 11,000 physicians and approximately one million patients each year. We maintain strategic joint venture relationships with approximately 4,000 physicians and over 50 prominent health systems. All but two of our facilities are co-owned with local physicians, and 154 are in strategic ventures with a health system. During 2014, we added ten facilities, consisting of three in Texas, two in New Jersey and one each in California, Georgia, Indiana, Missouri and South Dakota.

Our facilities generally specialize in non-emergency surgical cases. Due in part to advancements in medical technology, and additionally due to the lower cost structure and greater efficiency that are attainable in a specialized outpatient site, the volume and complexity of surgical cases performed in an outpatient setting has steadily increased over the past three decades. We believe continuing national focus on controlling the cost of healthcare will lead to further opportunities for high quality, low cost providers, such as USPI. Our strategy is to further enhance our value to our partners, employers, payors and patient populations in ways that build upon our historic experience and success, both in our existing facilities as well as additional acquired or developed facilities or other complementary businesses.

Our facilities' primary income source is a fee from patients, insurance companies or other payors in exchange for providing the facility and related services a surgeon requires in order to perform a surgical case. After providing for the related expenses of the case, including the nursing staff, supplies and property costs, each facility distributes its profit to us and the other owners. In addition, we earn a monthly fee from each facility we operate in exchange for managing its operations. How these income streams affect our financial statements depends on whether we consolidate each respective facility entity. Because our ownership levels and rights vary from facility to facility, we do not consolidate 156 of the 219 facilities that we operate, instead accounting for our investments in them under the equity method. To help analyze our results of operations, we disclose an operating measure we refer to as systemwide revenue growth, which includes both consolidated and unconsolidated (i.e., equity method) facilities. While revenues of our unconsolidated facilities are not recorded as revenues by USPI, we believe the information is important in understanding our financial performance 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. In addition, we disclose growth rates and operating income margins (both consolidated and unconsolidated) for the facilities that were operational in both the current and prior year periods, a group we refer to as same-store facilities.

Critical Accounting Policies and Estimates

Our discussion and analysis of our financial condition, results of operations and liquidity and capital resources are based on our consolidated financial statements, which have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP). The preparation of consolidated financial statements under GAAP requires our management to make certain estimates and assumptions that impact the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities as of the date of the consolidated financial statements. These estimates and assumptions also impact the reported amount of net earnings during any period. Estimates are based on information available as of the date

financial statements are prepared. Accordingly, actual results could differ from those estimates. Critical accounting policies and estimates are defined as those that are both most important to the portrayal of our financial condition and operating results and that require management's most subjective judgments. Our critical accounting policies and estimates include our policies and estimates regarding consolidation, revenue recognition and accounts receivable, income taxes, and goodwill and intangible assets.

Consolidation

We generally own less than 100% of each facility we operate. As discussed in "Results of Operations," local physicians have invested in all but two of our facilities. A majority of our facilities also include a health system partner. We generally have a leadership role in these facilities through a significant voting and economic interest and a contract to manage each facility's operations, but the degree of ultimate control we have varies from facility to facility. Accordingly, as of December 31, 2014, we consolidated the financial results of 63 of the facilities we operate and accounted for 156 under the equity method.

Our consolidated financial statements include our accounts, the accounts of our wholly owned subsidiaries, and other investees over which we have control or of which we are the primary beneficiary. Investments in companies that we do not control but over whose operations we have the ability to exercise significant influence (including some investees in which we have less than 20% ownership), are accounted for under the equity method. We also consider the relevant sections of the Financial Accounting Standards Board's *Accounting Standards Codification*, Topic 810, *Consolidation* to determine if we are the primary beneficiary of (and therefore should consolidate) any entity whose operations we do not control with voting rights. See further discussion in Note 5 to our consolidated financial statements.

Accounting for an investment as consolidated versus equity method has no impact on our net income (loss) or total equity in any accounting period, but it does impact individual balances within the consolidated statement of operations and consolidated balance sheet. Under either consolidation or equity method accounting, our results of operations include our share, generally corresponding to our ownership percentage, of the underlying facility's net income or loss.

Revenue Recognition and Accounts Receivable

We recognize revenue in accordance with Staff Accounting Bulletin No. 104, *Revenue Recognition in Financial Statements*, as updated, which has four criteria that must be met before revenue is recognized:

- Existence of persuasive evidence that an arrangement exists;
- Delivery has occurred or services have been rendered;
- The seller's price to the buyer is fixed or determinable; and
- Collectibility is reasonably assured.

Our revenue recognition policies are consistent with these criteria. Approximately 90% of our facilities' surgical cases are performed under contracted or government mandated fee schedules or discount arrangements. The patient service revenues recorded for these cases are recorded at the contractually defined amount at the time of billing. We estimate the remaining revenue based on historical collections, and adjustments to these estimates in subsequent periods have not had a material impact in any period presented. If the discount percentage used in estimating revenues for the cases not billed pursuant to fee schedules were changed by 1%, our 2014 after-tax net income would change by approximately $0.2 million. The collection cycle for patient services revenue is relatively short, typically ranging from 30 to 60 days depending upon payor and geographic norms, which allows us to evaluate our estimates frequently. Our revenues earned under management and other service contracts are typically based upon objective formulas driven by an entity's financial performance and are generally earned and paid monthly.

In 2014, uninsured or self-pay revenues only accounted for approximately 3% of our consolidated revenues and approximately 5% of our accounts receivable balance was comprised of amounts owed from patients,

including the patient portion of amounts covered by insurance. Insurance revenues (including government payors) accounted for 97% of our 2014 consolidated revenues and approximately 95% of our accounts receivable balance was comprised of amounts owed from contracted payors. Our facilities primarily perform surgery that is scheduled in advance by physicians who have already seen the patient. As part of our internal control processes, we verify benefits, obtain insurance authorization, calculate patient financial responsibility and notify the patient of their responsibility, usually prior to surgery. The nature of our business is such that we do not have any significant receivables that are pending approval from third-party payors. We also focus our collection efforts on aged accounts receivable. However, due to complexities involved in insurance reimbursements and inherent limitations in verification procedures, our business will always have some level of bad debt expense. In both 2014 and 2013, our bad debt expense was approximately 2% of revenue. In addition, as of December 31, 2014 and 2013, our average days sales outstanding were 36 days and 34 days, respectively. The aging of our accounts receivable at December 31, 2014 was 57% less than 60 days old, 17% between 60 and 120 days and 26% over 120 days old. Our bad debt allowance at December 31, 2014 and 2013 represented approximately 17% and 16% of our accounts receivable balance, respectively.

Due to the nature of our business, management relies upon the aging of accounts receivable as its primary tool to estimate bad debt expense, but also considers the impact of any known material events in determining the allowance for doubtful accounts. We reserve for bad debt based principally upon the aging of accounts receivable, without differentiating by payor source. We write off uncollectible accounts against the allowance for doubtful accounts after exhausting collection efforts and adding subsequent recoveries. We believe our reserve policy allows us to accurately estimate our allowance for doubtful accounts and bad debt expense.

Income Taxes

Our income tax policy is to record the estimated future tax effects of temporary differences between the tax bases of assets and liabilities and the bases of those assets and liabilities as reported in our consolidated balance sheets. This estimation process requires that we evaluate the need to accrue deferred tax liabilities or for a valuation allowance against deferred tax assets, based on factors such as historical financial information, expected timing of future events, the probability of expected future taxable income and available tax planning opportunities. We carry a valuation allowance against deferred tax assets that have restrictions as to use and are not considered more likely than not to be realized. If our estimates related to the above items change significantly, we may need to alter the amount of the valuation allowance in the future through a favorable or unfavorable adjustment to net income.

Goodwill and Intangible Assets

Given the significance of our intangible assets as a percentage of our total assets, we also consider our accounting policy regarding goodwill and intangible assets to be a critical accounting policy. Consistent with GAAP, we do not amortize goodwill or indefinite-lived intangibles but rather test them for impairment annually or more often when circumstances change in a manner that indicates they may be impaired. Impairment tests occur at the reporting unit level for goodwill. Historically, our reporting units were defined as our operating segments (United States and United Kingdom). Due to the spin-off of our U.K. subsidiary in April 2012, we now operate in one segment and test goodwill within one reporting unit. Our intangible assets consist primarily of indefinite-lived contractual rights to manage individual surgical facilities. Intangible assets with definite lives primarily consist of rights to provide management and other contracted services to surgical facilities, hospitals, and physicians. These assets are amortized over their estimated useful lives, and the portfolios are tested for impairment when circumstances change in a manner that indicates their carrying values may not be recoverable.

We performed a qualitative assessment to determine whether it was more-likely-than-not that the fair value of our reporting unit was less than its carrying amount for years ended December 31, 2014. In performing this qualitative assessment, we assessed relevant events and circumstances including macroeconomic conditions, industry and market conditions, cost factors, overall financial performance and entity-specific events. For the

year ended December 31, 2014, we concluded it was more-likely-than-not that the fair value of our reporting unit exceeded its carrying value. Therefore, the two-step goodwill impairment test was not required and there was no impairment of goodwill.

In tests for impairment of indefinite-lived intangible assets, the fair value of the asset is compared to its carrying amount. If the carrying amount exceeds the fair value, an impairment loss is recognized. Fair values for indefinite-lived intangible assets are estimated based on market multiples and discounted cash flow models which have been derived based on our experience in aequiring surgical facilities, market participant assumptions and third-party valuations we have obtained with respect to such transactions.

Merger Transaction

We had publicly traded equity securities from June 2001 through April 2007. Pursuant to an Agreement and Plan of Merger (the merger) dated as of January 7, 2007, between an affiliate of Welsh, Carson, Anderson & Stowe X, L.P. (Welsh Carson), we became a wholly owned subsidiary of USPI Holdings, Inc. on April 19, 2007. USPI Holdings is a wholly owned subsidiary of USPI Group Holdings, Inc. (Parent), which is owned by an investor group that includes affiliates of Welsh Carson, members of our management and other investors.

Acquisitions, Equity Investments and Development Projects

We acquire interests in existing surgery facilities from third parties, and we invest in new facilities that we develop in partnership with health system partners and local physicians. Some of these transactions result in our controlling the acquired entity and meet the GAAP definition of a business combination. The financial results of acquired entities are included in our consolidated financial statements beginning on the acquisition's effective date. During the year ended December 31, 2014, the Company obtained control of the following entities:

Effective Date	Facility Location	Amount
February 2014	Georgia(1)	$ 2.0 million
September 2014	Missouri(1)	1.0 million
December 2014	Illinois(2)	— million
Total		$ 3.0 million

(1) Acquisition of a controlling interest in and right to manage a surgical facility in which we previously had no involvement. The facility is jointly owned with local physicians.

(2) We obtained control of this facility in which we already had ownership due to changes in the voting rights of the facility. Although no consideration was transferred, GAAP requires the transaction to be accounted for as a business combination. This facility is jointly owned with local physicians.

We also regularly engage in the purchase and sale of equity interests with respect to our investments in unconsolidated affiliates that do not result in a change of control. These transactions are primarily the acquisitions and sales of equity interests in unconsolidated surgical facilities and the investment of additional cash in unconsolidated affiliates that need capital for acquisitions, new construction or other business growth opportunities. During the year ended December 31, 2014, these transactions resulted in a net cash outflow of approximately $146.9 million, which is summarized as follows:

Effective Date	Facility Location	Amount
March 2014	Indiana(1)	$ 32.3 million
April 2014	New Jersey(1)	17.0 million
June 2014	Dallas-Fort Worth(2)	4.2 million
July 2014	South Dakota(3)	52.0 million
July 2014	New Jersey(1)	26.8 million
October 2014	California(3)	10.2 million
Various	Various(4)	4.4 million
Total		$ 146.9 million

(1) Acquisition of a noncontrolling interest in and the right to manage a surgical facility in which we previously had no involvement. The facility is jointly owned with local physicians.

(2) Acquisition of a noncontrolling interest in and the right to manage two surgical facilities in which we previously had no involvement. These facilities are jointly owned with a health system partner and local physicians.

(3) Acquisition of a noncontrolling interest in and the right to manage a surgical facility in which we previously had no involvement. The facility is jointly owned with a health system partner and local physicians.

(4) Represents the net payment related to various other purchases and sales of equity interests and contributions of cash to equity method investees.

Similar to our investments in unconsolidated affiliates, we regularly engage in the purchase and sale of equity interests in our consolidated subsidiaries that do not result in a change of control. These types of transactions are accounted for as equity transactions, as they are undertaken among us, our consolidated subsidiaries, and noncontrolling interests. During the year ended December 31, 2014, we purchased and sold equity interests in various consolidated subsidiaries in the amounts of $8.8 million and $6.2 million, respectively. The difference between our carrying amount and the proceeds received or paid in each transaction is recorded as an adjustment to our additional paid-in capital. These transactions resulted in a $12.0 million decrease to our additional paid-in capital during the year ended December 31, 2014.

During the year ended December 31, 2014, the Company received a return of capital in the amount of $22.0 million from one of its unconsolidated affiliates.

During the year ended December 31, 2013, we obtained control of the following entities:

Effective Date	Facility Location	Amount
December 2013	Texas(1)	$ 12.4 million
May 2013	Texas(1)	1.5 million
May 2013	Texas(2)	4.9 million
Total		$ 18.8 million

(1) Acquisition of a controlling interest in and right to manage a surgical facility in which we previously had no involvement. The facility is jointly owned with a health system partner and local physicians.

(2) Acquisition of a controlling interest in a surgical facility in which we already had ownership and already managed. The facility is jointly owned with a health system partner and local physicians. We recorded a loss of approximately $0.8 million as a result of adjusting the carrying value of its existing ownership to fair value as required by GAAP. The loss is included in "Net losses on deconsolidations, disposals and impairments" in our accompanying consolidated statements of income.

We also regularly engage in the purchase and sale of equity interests with respect to our investments in unconsolidated affiliates that do not result in a change of control. These transactions are primarily the acquisitions and sales of equity interests in unconsolidated surgical facilities and the investment of additional cash in unconsolidated affiliates that need capital for acquisitions, new construction or other business growth opportunities. During the year ended December 31, 2013, these transactions resulted in a net cash outflow of approximately $33.3 million, which is summarized as follows:

Effective Date	Facility Location	Amount
December 2013	Texas(1)	$ 22.0 million
December 2013	Illinois(2)	5.1 million
August 2013	Texas(3)	2.4 million
Various	Various(4)	3.8 million
Total		$ 33.3 million

(1) Investment of additional funds in an existing joint venture with one of our health system partners.

(2) Acquisition of additional ownership in a surgical facility in which we already held ownership and already managed. The facility is jointly owned with local physicians.

(3) Acquisition of an investment in a partnership that is constructing a new building for one of our facilities.

(4) Represents the net payment related to various other purchases and sales of equity interests and contributions of cash to equity method investees.

Similar to our investments in unconsolidated affiliates, we regularly engage in the purchase and sale of equity interests in our consolidated subsidiaries that do not result in a change of control. These types of transactions are accounted for as equity transactions, as they are undertaken among us, our consolidated subsidiaries, and noncontrolling interests. During the year ended December 31, 2013, we purchased and sold equity interests in various consolidated subsidiaries in the amounts of $5.7 million and $4.1 million, respectively. The difference between our carrying amount and the proceeds received or paid in each transaction is recorded as an adjustment to our additional paid-in capital. These transactions resulted in a $3.9 million decrease to our additional paid-in capital during the year ended December 31, 2013.

During the year ended December 31, 2012, we obtained control of the following entities:

Effective Date	Facility Location	Amount
November 2012	Various(1)	$ 65.4 million
November 2012	New Jersey(2)	— million
October 2012	Tennessee(3)	4.6 million
June 2012	New Jersey(4)	17.1 million
Total		$ 87.1 million

(1) As further discussed below, we acquired 100% of the equity interests of AIGB Holdings, Inc. (True Results). True Results has an equity investment in five surgery centers, all of which are located in markets in which we already operate. The purchase price noted above is net of approximately $5.8 million of cash acquired.

(2) We obtained control of this facility in which we already had ownership due to changes in the voting rights of the facility. Although no consideration was transferred, GAAP requires the transaction to be accounted for as a business combination and requires adjusting the carrying value of our existing ownership to its fair value. As a result, we recorded a loss totaling approximately $6.5 million for the year ended December 31, 2012, which is included in "Net losses on deconsolidations, disposals and impairments" in the accompanying consolidated statements of income.

(3) Acquisition of a controlling interest in and right to manage a surgical facility in which we previously had no involvement. This facility is jointly owned with local physicians and a health system partner.

(4) Acquisition of a controlling interest in a surgical facility in which we already had an equity method investment and the right to manage. This facility is jointly owned with local physicians. We recorded a gain of approximately $0.2 million as a result of adjusting the carrying value of our existing ownership to fair value as required by GAAP. The gain is included in "Net losses on deconsolidations, disposals and impairments" in the accompanying consolidated statements of income.

Effective November 8, 2012, we completed the acquisition of 100% of the equity interests in True Results, a privately-held, Dallas, Texas-based owner and operator of surgery centers specializing in weight loss services. We paid cash totaling approximately $65.4 million, which is net of $5.8 million of cash acquired, subject to certain purchase price adjustments set forth in the purchase agreement. We funded the purchase using cash on hand and by drawing on our revolving credit facility. We incurred approximately $0.7 million in acquisition costs, which are included in "general and administrative expenses" in the accompanying consolidated statements of income.

In January 2013, we contributed two of the surgery centers acquired in the True Results acquisition to a joint venture with one of our health system partners, a Baylor Scott & White Health affiliated entity (Baylor Scott & White). Baylor Scott & White, which is a related party, paid us approximately $9.0 million for ownership interests in the two surgery centers, which we believe approximates fair value as if it had been negotiated on an arms' length basis. We continue to account for these facilities under the equity method.

We also regularly engage in the purchase and sale of equity interests with respect to our investments in unconsolidated affiliates that do not result in a change of control. These transactions are primarily the acquisitions and sales of equity interests in unconsolidated surgical facilities and the investment of additional cash in surgical facilities under development. During the year ended December 31, 2012, these transactions resulted in a net cash outflow of approximately $54.5 million, which is summarized as follows:

Effective Date	Facility Location	Amount
December 2012	Illinois(1)	$ 23.4 million
December 2012	Louisiana(2)	9.2 million
December 2012	California(2)	0.7 million
September 2012	New Jersey(3)	12.3 million
March 2012	Arizona(2)	0.8 million
February 2012	Texas(2)	3.0 million
Various	Various(4)	5.1 million
Total		$ 54.5 million

(1) Acquisition of a noncontrolling interest in and right to manage a surgical facility in which we previously had no involvement. The facility is jointly owned with local physicians.

(2) Acquisition of a noncontrolling interest in and right to manage a surgical facility in which we previously had no involvement. The facility is jointly owned with a health system partner and local physicians.

(3) Acquisition of a noncontrolling interest in and right to manage two surgical facilities in Hackensack and Paramus, New Jersey, respectively, in which we previously had no involvement. The facilities are jointly owned with a health system partner and local physicians.

(4) Represents the net payment related to various other purchases and sales of equity interests and contributions of cash to equity method investees.

Similar to our investments in unconsolidated affiliates, we regularly engage in the purchase and sale of equity interests in our consolidated subsidiaries that do not result in a change of control. These types of

transactions are accounted for as equity transactions, as they are undertaken among us, our consolidated subsidiaries, and noncontrolling interests. During the year ended December 31, 2012, we purchased and sold equity interests in various consolidated subsidiaries in the amounts of $4.0 million and $8.8 million, respectively. The difference between our carrying amount and the proceeds received or paid in each transaction is recorded as an adjustment to our additional paid-in capital. These transactions resulted in a $17.1 million decrease to our additional paid-in capital during the year ended December 31, 2012.

Discontinued Operations, Deconsolidations and Other Dispositions

Before the adoption of Financial Accounting Standards Board (FASB) *Accounting Stondards Updote* 2014-08, *Reparting Discontinued Operations and Disclosures of Disposals of Components of on Entity* (ASU 2014-08) in 2014, we classified formerly consolidated subsidiaries in which it had no continuing involvement as discontinued operations. The gains or losses on these transactions were classified within discontinued operations in our consolidatcd statements of income. We also reclassified the historical results of thesc subsidiaries to remove the operations of these entities from our revenues and expenses, collapsing the net income or loss from these opcrations into a single line within discontinued operations. On April 3, 2012, we distributed the stock of our U.K. subsidiary to our Parent's equity holders. Subsequent to April 3, 2012, we have no ownership in the U.K. operations. Because GAAP requires spin-off transactions to be accounted for at carrying value, there was no gain or loss recorded on the spin-off of the U.K. operations. Our U.K. operations are now classified as "discontinued operations" in our historical results of operations.

In 2014 and 2012, we complcted sales of investments in two facilities operated through unconsolidated affiliates, including our equity ownership in these entities as well as the related rights to manage the facilities. These transactions do not qualify for discontinued operations presentation. We did not dispose of any facility we operated through an unconsolidated affiliate during 2013. Gains and losses on the disposals of these investments are classified within "Net losses on deconsolidations, disposals and impairments" in the accompanying consolidated statements of income. These transactions are summarized below:

Date	Facility Location	Proceeds (Payment)	Gain (Loss)
August 2014	Pennsylvania	$ (1.2) million	$ (1.2 million)
July 2012	Tennessee	0.5 million	0.3 million

From time to time, we surrender control of an entity but retain a noncontrolling interest (classified within "investments in unconsolidated affiliates"). These types of transactions result in a gain or loss, computed as the difference between (a) the sales proceeds and fair value of thc retained investment and (b) our carrying value of the investment prior to the transaction. Gains or losses for such transactions are classified within "Net losses on deconsolidations, disposals and impairments" in the accompanying consolidated statements of income. Fair values are estimated based on market multiples and discounted cash flow models which have been derived from our experience in acquiring surgical facilities and third party valuations we have obtained with respect to such transactions. During the year ended December 31, 2014, we surrendered control of, but retained an equity method investment in, two entities as part of our strategy of partnering with health systems. These transactions are summarized below:

Effective Date	Facility Location	Proceeds (Payment)	Gain
June 2014	Florida	$ 1.5 million	$1.2 million
October 2014	Texas	(1.2) million	0.9 million
Total		$ 0.3 million	$2.1 million

Sources of Revenue

Revenues primarily include the following:

- net patient service revenues of the facilities that we consolidate for financial reporting purposes, which are those in which we maintain effective control, generally indicated by an ownership interest of greater than 50% but also including variable interest entities of which we are the primary beneficiary;
- management and contract service revenues, consisting of the fees that we earn from managing the facilities that we do not consolidate for financial reporting purposes and the fees we earn from providing certain consulting and contracted services to other healthcare providers. Our consolidated revenues and expenses do not include the management fees we earn from operating the facilities that we consolidate for financial reporting purposes as those fees are charged to subsidiaries and thus are eliminated in consolidation.

The following table summarizes our revenues by type and as a percentage of total revenue for the periods presented:

	Years Ended December 31,		
	2014	2013	2012
Net patient service revenues	83%	84%	84%
Management and contract service revenues	15	14	15
Other revenues	2	2	1
Total revenues	100%	100%	100%

Net patient service revenues consist of the revenue earned by the facilities we consolidate for financial reporting purposes. As a percent of our total revenues, these revenues did not change significantly compared to prior year periods. Revenues earned by our unconsolidated affiliates for similar services are not included in our revenues. The percentage of our facilities we account for under the equity method was approximately 70% at December 31, 2014, 2013, and 2012.

Our management and contract service revenues are earned from the following types of activities (in thousands):

	Years Ended December 31,		
	2014	2013	2012
Management of unconsolidated surgical facilities	$85,000	$77,118	$68,660
Contract services provided to other healthcare providers	11,392	10,441	10,778
Total management and contract service revenues	$96,392	$87,559	$79,438

As described above, we also earn management fees from consolidated facilities, but those fees are eliminated in consolidation and thus are not included in revenues on our consolidated statements of income.

Results of Operations

The following table summarizes certain consolidated statements of income items expressed as a percentage of revenues for the periods indicated:

	Years Ended December 31,		
USPI	2014	2013	2012
Total revenues	100.0%	100.0%	100.0%
Equity in earnings of unconsolidated affiliates	18.2	15.5	17.8
Operating expenses, excluding depreciation and amortization	(72.0)	(68.3)	(68.0)
Depreciation and amortization	(4.1)	(4.4)	(4.4)
Operating income	42.1	42.8	45.4
Interest and other expense, net	(14.6)	(17.1)	(22.8)
Income from continuing operations before income taxes	27.5	25.7	22.6
Income tax expense	(5.9)	(5.1)	(4.0)
Income from continuing operations	21.6	20.6	18.6
Earnings (loss) from discontinued operations, net of tax	(0.1)	—	0.6
Net income	21.5	20.6	19.2
Less: Net income attributable to noncontrolling interests	(12.0)	(12.8)	(13.5)
Net income attributable to USPI's common stockholder	9.5%	7.8%	5.7%

Our business model of partnering with health system partners and physicians results in our accounting for 156 of our surgical facilities under the equity method rather than consolidating their results. The following table reflects the summarized results of the unconsolidated facilities that we account for under the equity method of accounting (amounts are expressed as a percentage of unconsolidated affiliates' revenues, and represent 100% of the investees' results on an aggregated basis):

	Years Ended December 31,		
USPI's Unconsolidated Affiliates	2014	2013	2012
Revenues	100.0%	100.0%	100.0%
Operating expenses, excluding depreciation and amortization	(69.5)	(71.2)	(70.2)
Depreciation and amortization	(3.8)	(4.1)	(4.1)
Operating income	26.7	24.7	25.7
Interest expense, net	(1.5)	(1.7)	(2.0)
Income before income taxes	25.2	23.0	23.7
Income tax expense	(0.4)	(0.5)	(0.5)
Net income	24.8%	22.5%	23.2%

Our share of the net income of unconsolidated affiliates is shown in our consolidated statements of income on a net basis as "equity in earnings of unconsolidated affiliates."

Executive Summary

We are an experienced and trusted partner in some of the nation's most successful surgical networks. We provide strategic solutions for physicians, physician networks, leading health systems and those paying for the cost of healthcare services, such as employers, insurance companies and government programs.

Our portfolio includes 219 short-stay surgical facilities in 27 states. In these facilities, which are licensed as either ambulatory surgery centers, specialty hospitals or hospitals, we serve approximately 11,000 physicians and one million patients each year. We maintain strategic joint venture relationships with approximately 4,000

physicians and over 50 prominent health systems. All but two of our facilities are co-owned with local physicians, and 154 of our facilities are in strategic joint ventures with a health system. Our strategy continues to include acquiring facilities, developing new facilities with health system partners, and improving the operating results of our existing facilities. During 2014, we added ten facilities, consisting of three in Texas, two in New Jersey and one each in California, Georgia, Indiana, Missouri and South Dakota.

Our facilities generally specialize in non-emergency surgical cases. Due in part to advancements in medical technology, and additionally due to the lower cost structure and greater efficiency that are attainable in a specialized outpatient site, the volume and complexity of surgical cases performed in an outpatient setting has steadily increased over the past three decades. We believe the continuing national focus on controlling the cost of healthcare will lead to further opportunities for high quality, low cost providers, such as us. Our strategy is to further enhance our value to our partners, employers, payors and patient populations in ways that build upon our historic experience and success, both in our existing facilities as well as additional acquired or developed facilities or other complementary businesses.

Our earnings from a facility, whether consolidated or equity method, are driven by the same factors: the facility's underlying profits and revenues and our ownership percentage. Accordingly, to assess our overall operating results we often utilize systemwide and same-store measures, which include both consolidated and unconsolidated facilities. Our operating results for the year ended December 31, 2014, reflect 5% same-store facility revenue growth as compared to 2013, and our overall business also grew as a result of our operating more facilities in 2014. Our consolidated revenue growth in 2014 was 4% and our systemwide revenue growth was 8%. Our systemwide revenues include all facilities that we operate; our revenues only include consolidated facilities, which represent less than one-third of our facilities. Accounting for the majority of our facilities under the equity method is a direct result of deploying our primary business strategy of jointly owning our facilities with prominent local physicians and a health system partner. In carrying out this strategy during the period from January 1, 2013 to December 31, 2014, our number of equity method facilities increased from 149 to 156 while our consolidated facility count decreased from 64 to 63.

Operating income increased 2% and operating income margin decreased 70 basis points during 2014 as compared to 2013. In addition to our consolidated operating income margin, we also focus on same-store facility level operating income margins (which include both consolidated and equity method facilities) as important indicators of our business because the net earnings and cash flows we derive from our facilities are the same whether they are reflected in our individual revenue and expense line items (consolidated facilities) or on a net basis within our equity in earnings of unconsolidated affiliates (unconsolidated facilities). These margins were flat in 2014 as compared to 2013.

Our Business and Key Measures

We operate surgical facilities in partnership with local physicians and, in the majority of cases, a health system partner. We hold an ownership interest in each facility, operating each through a separate legal entity owned by us, the health systems and local physicians who utilize the facility. We operate each facility on a day-to-day basis through a management services contract. Our sources of earnings from each facility consist of:

- our share of each facility's net income or loss, which is computed by multiplying the facility's net income or loss times the percentage of each facility's equity interests owned by us; and
- management services revenues, computed as a percentage of each facility's net revenues (often net of bad debt expense).

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. In a majority of our facilities (currently 156 of our 219 facilities), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method, i.e., as an unconsolidated affiliate. We control the other 63 facilities and account for these investments as consolidated subsidiaries.

Our net earnings from a facility are the same under either method, but the classification of those earnings differs. For consolidated subsidiaries, our consolidated statements of income reflect, within each revenue and expense line item, 100% of the revenues and expenses of each subsidiary, after the elimination of intercompany amounts. The net profit attributable to owners other than us is classified within "net income attributable to noncontrolling interests."

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

- equity in earnings of unconsolidated affiliates: our share of the net income or loss of each facility, which is based on the facilities' net income or loss and the percentage of the facility's outstanding equity interests owned by us; and
- management and administrative services revenues: income we earn in exchange for managing the day-to-day operations of each facility, usually quantified as a percentage of each facility's net revenues less bad debt expense.

In summary, our operating income is driven by the performance of all facilities we operate and by our ownership interest in those facilities, but our individual revenue and expense line items only contain consolidated businesses, which represent less than one-third of our operations. This translates to trends in operating income that often do not correspond with changes in our individual revenue and expense line items. The divergence in these relationships is particularly significant when our strategy is heavily weighted to unconsolidated affiliates, as it has been in recent years during the ongoing deployment of our strategy to partner with health systems. Accordingly, we supplementally review several types of information in order to monitor and analyze our results of operations, including:

- The results of operations of our unconsolidated affiliates
- Our average ownership share in the facilities we operate; and
- Facility operating indicators irrespective of consolidation treatment, such as systemwide revenue growth, same-store revenue growth, and same-store operating margins.

Our Consolidated and Unconsolidated Results

The following table shows our results of operations and the results of operations of our unconsolidated affiliates.

	Year Ended December 31,					
	2014		2013		Variance to Prior Year	
	USPI As Reported Under GAAP	Unconsolidated Affiliates	USPI As Reported Under GAAP	Unconsolidated Affiliates	USPI As Reported Under GAAP	Unconsolidated Affiliates
Revenues:						
Net patient service revenues	$ 533,811	$ 1,954,994	$ 517,738	$ 1,778,247	$ 16,073	$ 176,747
Management and contract service revenues	96,392	—	87,559	—	8,833	—
Other income	10,621	11,675	18,934	11,694	(313)	(19)
Total revenues	640,824	1,966,669	616,231	1,789,941	24,593	176,728
Equity in earnings of unconsolidated affiliates	116,607	—	95,520	—	21,087	—
Operating expenses:						
Salaries, benefits, and other employee costs	175,463	462,379	163,667	434,627	11,796	27,752
Medical services and supplies	109,636	478,273	101,149	438,616	8,487	39,657
Other operating expenses	110,642	396,823	99,425	361,359	11,217	35,464
General and administrative expenses	48,365	—	41,458	—	6,907	—
Provision for doubtful accounts	10,658	47,283	10,006	41,202	652	6,001
Net (gains) losses on deconsolidations, disposals and impairments	6,887	(17,905)	5,017	(2,837)	1,870	(15,868)
Depreciation and amortization	26,004	75,097	27,238	72,921	(1,234)	2,176
Total operating expenses	487,655	1,441,870	447,960	1,346,688	39,695	95,182
Operating income	269,776	524,799	263,791	443,253	5,985	81,546
Interest income	1,287	388	1,359	369	(72)	19
Interest expense	(95,028)	(29,061)	(101,163)	(31,484)	6,135	2,423
Loss on early retirement of debt	—	(202)	(5,536)	—	5,536	(202)
Other, net	(68)	435	(2)	(197)	(66)	632
Total other expense, net	(93,809)	(28,440)	(105,342)	(31,312)	11,533	2,872
Income from continuing operations before income taxes	175,967	496,359	158,449	411,941	17,518	84,418
Income tax expense	(37,507)	(7,923)	(31,389)	(9,046)	(6,118)	1,123
Income from continuing operations	138,468	488,436	127,060	402,895	11,400	85,541
Loss from discontinued operations, net	(332)	—	—	—	(332)	—
Net income	138,128	$ 488,436	127,060	$ 402,895	11,868	$ 85,541
Less: Net income attributable to noncontrolling interests	(77,081)		(78,782)		1,701	
Net income attributable to USPI	$ 61,047		$ 48,278		$ 12,769	
USPI's equity in earnings of unconsolidated affiliates		$ 116,607		$ 95,520		$ 21,087

	Year Ended December 31,					
	2013		2012		Variance to Prior Year	
	USPI As Reported Under GAAP	Unconsolidated Affiliates	USPI As Reported Under GAAP	Unconsolidated Affiliates	USPI As Reported Under GAAP	Unconsolidated Affiliates
Revenues:						
Net patient service revenues	$ 517,738	$ 1,778,247	$ 451,598	$ 1,721,559	$ 66,140	$ 56,688
Management and contract service revenues	87,559	—	79,438	—	8,121	—
Other income	10,934	11,694	9,199	10,346	1,735	1,348
Total revenues	616,231	1,789,941	540,235	1,731,905	75,996	58,036
Equity in earnings of unconsolidated affiliates	95,520	—	96,393	—	(873)	—
Operating expenses:						
Salaries, benefits, and other employee costs	163,667	434,627	138,020	401,521	25,647	33,106
Medical services and supplies	101,149	438,616	83,546	429,516	17,603	9,100
Other operating expenses	99,425	361,359	87,173	344,921	12,252	16,438
General and administrative expenses	41,458	—	41,434	—	24	—
Provision for doubtful accounts	10,006	41,202	9,678	45,306	328	(4,104)
Net (gains) losses on deconsolidations, disposals and impairments	5,017	(2,037)	7,588	(6,280)	(2,571)	4,243
Depreciation and amortization	27,238	72,921	23,955	72,027	3,283	894
Total operating expenses	447,960	1,346,688	391,394	1,287,011	56,566	59,677
Operating income	263,791	443,253	245,234	444,894	18,557	(1,641)
Interest income	1,359	369	676	350	683	19
Interest expense	(101,163)	(31,484)	(85,934)	(34,901)	(15,229)	3,417
Loss on early retirement of debt	(5,536)	—	(37,450)	—	31,914	—
Other, net	(2)	(197)	(613)	426	611	(623)
Total other expense, net	(105,342)	(31,312)	(123,321)	(34,125)	17,979	2,813
Income from continuing operations before income taxes	158,449	411,941	121,913	410,769	36,536	1,172
Income tax expense	(31,389)	(9,046)	(21,502)	(8,576)	(9,887)	(470)
Income from continuing operations	127,060	402,895	100,411	402,193	26,649	702
Earnings from discontinued operations, net	—	—	3,073	—	(3,073)	—
Net income	127,060	$ 402,895	103,484	$ 402,193	23,576	$ 702
Less: Net income attributable to noncontrolling interests	(78,782)		(72,693)		(6,089)	
Net income attributable to USPI	$ 48,278		$ 30,791		$ 17,487	
USPI's equity in earnings of unconsolidated affiliates		$ 95,520		$ 96,393		$ (873)

The following table provides other information regarding our unconsolidated affiliates (in thousands):

	Years Ended December 31,		
	2014	2013	2012
Long-term debt of USPI's unconsolidated facilities	$356,168	$377,458	$407,172
USPI's equity in earnings of unconsolidated affiliates	116,607	95,520	96,393
USPI's imputed weighted average ownership percentage based on affiliates' pretax income(1)	23.5%	23.2%	23.5%
USPI's imputed weighted average ownership percentage based on affiliates' debt(2)	25.8%	26.2%	26.2%
Unconsolidated facilities operated at period end	156	149	149

(1) Our weighted average percentage ownership in our unconsolidated affiliates is calculated as our equity in earnings of unconsolidated affiliates divided by the total net income (loss) of unconsolidated affiliates for each respective period. This is a non-GAAP measure but management believes it provides further useful information about our involvement in unconsolidated affiliates.

(2) Our weighted average percentage ownership in our unconsolidated affiliates is calculated as the total debt of each unconsolidated affiliate, multiplied by the percentage ownership we held in the affiliate as of the end of each respective period, divided by the total debt of all of the unconsolidated affiliates as of the end of each respective period. This is a non-GAAP measure but management believes it provides further useful information about our involvement in unconsolidated affiliates.

One of our unconsolidated affiliates, Texas Health Ventures Group, L.L.C., is considered significant to our consolidated financial statements under regulations of the SEC. As a result, we have filed Texas Health Ventures Group, L.L.C.'s consolidated financial statements with this Form 10-K for the appropriate periods.

As shown above, our consolidated net patient service revenues for the year ended December 31, 2014 increased $16.1 million compared to the prior year, and the net patient service revenues of our unconsolidated affiliates increased $176.7 million. These variances are analyzed more extensively in the "Revenues" section. The increase in revenues of these unconsolidated affiliates, net of their expenses, led to the affiliates earning $85.5 million more in 2014 than in 2013, which resulted in a $21.1 million increase in our equity in earnings of unconsolidated affiliates. Our consolidated net patient service revenues for the year ended December 31, 2013 increased $66.1 million compared to the prior year, and the net patient service revenues of our unconsolidated affiliates increased $56.7 million.

Our Ownership Interests in the Facilities We Operate

Our earnings are primarily driven by our investments in the facilities we operate, so we focus on those businesses' performance together with the percentage ownership interest we hold in them to help us understand our results of operations. Our average ownership interest in the surgical facilities we operate is as follows:

	Year Ended December 31, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012
Unconsolidated facilities(1)	23.9%	23.7%	24.0%
Consolidated facilities(2)	42.9%	45.5%	44.2%
Total(3)	28.0%	29.0%	28.5%

(1) Computed for unconsolidated facilities by dividing (a) our total equity in earnings of unconsolidated affiliates by (b) the aggregate net income of surgical facilities we account for under the equity method.

(2) Computed for consolidated facilities by dividing (a) the aggregate net income (loss) of surgical facilities we operate less our total minority interests in income (loss) of consolidated subsidiaries by (b) the aggregate net income of our consolidated surgical facilities.

(3) Computed in total by dividing our share of the facilities' net income (loss), defined as the sum of (a) in footnotes (1) and (2), by the aggregate net income of our surgical facilities, defined as the sum of (b) in footnotes (1) and (2).

Our average ownership interest for each group of facilities is determined by many factors, including the ownership levels we negotiate in our acquisition and development activities, the relative performance of facilities in which we own percentages higher or lower than average, and other factors. As described earlier, our focus on partnering our facilities with health system partners in addition to physicians generally leads to our accounting for more facilities under the equity method (unconsolidated) as reflected in our number of unconsolidated facilities increasing by seven from January 1, 2013 to December 31, 2014, while our number of consolidated facilities decreased by one. We generally have a lower ownership percentage in an equity method facility as compared to a consolidated facility.

Revenues

Our consolidated net revenues increased approximately 4% during the year ended December 31, 2014, as compared to the year ended December 31, 2013. The table below quantifies several significant items impacting year over year growth.

	Year Ended December 31, 2014	
	USPI as Reported Under GAAP	Unconsolidated Affiliates
Total revenues, year ended December 31, 2013	$ 616,231	$ 1,789,941
Revenue from acquired facilities	15,335	83,168
Changes in consolidation status	(1,719)	1,719
Revenue of disposed facilities	(1,292)	(732)
Adjusted base year	628,555	1,874,096
Increase from operations	12,582	92,592
Non-facility based revenue	(313)	(19)
Total revenues, year ended December 31, 2014	$ 640,824	$ 1,966,669

As shown above, the increases in our consolidated revenues and the revenues of our unconsolidated affiliates resulted from both acquisitions, which added $15.3 million and $83.2 million to revenues for consolidated and unconsolidated affiliates, respectively and from same-store growth, which added $12.6 million to consolidated revenues and $92.6 million to unconsolidated affiliates. As described earlier, we supplementally focus on our systemwide results in order to understand the source of our growth in income. Our systemwide revenues, which include revenues of facilities we account for under the equity method as well as facilities we consolidate, grew by 8%, 6% and 12% during the years ended December 31, 2014, 2013 and 2012, respectively.

Facility Growth

For the year ended December 31, 2014, systemwide revenues increased due to same-store growth and acquisitions that were made in 2013 and 2014. Our same-store case volumes increased 1% as compared to 2013, and our net revenue per case increased 4%, which was driven by a shift to more complex cases during 2014. While cases increased 1% overall during 2014, they were flat during 2013. We believe a variety of factors may be adversely affecting our surgical volumes, including but not limited to the increased use of high-deductible health plans and other efforts to contain the growth of healthcare spending, and general economic conditions.

During 2013, while systemwide revenue growth was primarily driven by acquisitions, a portion of growth was driven by facilities that have been open for more than one year (same-store facilities). The same-store

growth was due to an increase in net revenue per case as our surgical volumes were flat during 2013 as compared to 2012. The increase was driven both by reimbursement increases from commercial payors and by favorable shifts in the complexity of cases performed, offset by a shift in payor mix to government.

The following table summarizes our same-store facility growth rates, as compared to the corresponding prior year period:

	Years Ended December 31,		
	2014	2013	2012
Net revenue	5%	1%	6%
Surgical cases	1%	—%	3%
Net revenue per case	4%	1%	3%

Joint Ventures with Health System Partners

The addition of new facilities continues to be slightly more heavily weighted to surgical facilities with a health system partner, both as we initiate joint venture agreements with new systems and as we add facilities to our existing arrangements. Facilities have been added to hospital joint ventures through construction of new facilities (de novos), acquisitions of facilities and through our contribution of our equity interests in existing facilities into a hospital joint venture structure, effectively creating three-way joint ventures by sharing our ownership in these facilities with a health system partner while leaving the existing physician ownership intact. We continue to explore affiliating more of our facilities with health system partners. Often these affiliations are initiated in markets where we already operate other facilities with a health system partner, but we also affiliate our facilities with new partners.

The following table summarizes the facilities we operated as of December 31, 2014, 2013, and 2012:

	2014	2013	2012
Facilities(1):			
With a health system partner	154	148	145
Without a health system partner	65	66	68
Total facilities operated	219	214	213
Change from prior year-end:			
De novo (newly constructed)	—	1	2
Acquisition	10	2	15
Disposals(2)	(5)	(2)	(10)
Total increase in number of facilities	5	1	7

(1) At December 31, 2014, physicians own a portion of all but two of these facilities.

(2) During 2014, we sold two facilities in Pennsylvania and merged four Missouri locations into two locations. During 2013, we sold our ownership interests in a facility in Illinois and merged two Texas facilities into one location. During 2012, we sold our ownership interests in a facility in Nashville, Tennessee. We also merged two Texas facilities into one location and two of our California facilities into one location.

Facility Operating Margins

Same-store facility operating margins were flat for the year ended December 31, 2014 as compared to 2013. Our same-store facility operating margins declined 220 basis points during the first quarter of 2014 due to a decline in case volumes and an unfavorable shift in payor mix. Our case volumes and payor mix improved in later quarters, and we also experienced a shift to more complex cases. Overall, these factors together with cost control efforts led to our margins being flat compared to 2013 on a full year basis.

Continuing a trend we have experienced in recent years, the year-over-year change in the operating margins of facilities partnered with a health system partner was more favorable (or, in the case of 2013 and 2012, less unfavorable) than the change experienced by the facilities that do not have a health system partner. During 2014, our hospital-partnered facilities' operating margins increased 70 basis points, as compared to a decrease of 280 basis points for the facilities that do not have health system partners. We believe this is due in part to our hospital-partnered facilities having more stable reimbursement rates and in some cases more stable referral patterns. The pattern of our acquisition and development activity can also affect this relationship over time.

Same-store facility operating margins decreased 160 basis points for the year ended December 31, 2013 as compared to 2012 due largely to a shift toward more government payors. The direct costs of performing these cases are not different for government than for private payors, but reimbursement is lower so our margins were adversely impacted. We also experienced a slight specialty mix shift from higher reimbursing musculoskeletal cases to lower reimbursing specialties. The impact of these two factors was particularly significant in our unconsolidated facilities, where a 3% increase in revenues did not translate to any increase in net earnings.

The following table summarizes our year-over-year increases (decreases) in same-store operating margins (see footnote 1 below):

	Year Ended December 31,		
	2014	2013	2012
With a health system partner	70 bps	(150) bps	(20) bps
Without a health system partner	(280)	(230)	(300)
Total facilities	—	(160)	(80)

(1) Operating margin is calculated as operating income divided by total net revenues. This table aggregates all of the same-store facilities we operate using 100% of their results. This does not represent the overall margin for our operations because we have a variety of ownership levels in the facilities we operate, and facilities open for less than a year are excluded from same-store calculations.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

As discussed more fully in "Revenues," our consolidated revenues increased by $24.6 million, or 4.0%, to $640.8 million for the year ended December 31, 2014 from $616.2 million for the year ended December 31, 2013. The increase in consolidated revenues was due to acquisitions ($15.3 million), consolidation of a facility ($7.3 million) and an increase from operations ($12.3 million), which was offset by deconsolidations of three facilities and the sale of one facility of approximately $10.3 million.

Equity in earnings of unconsolidated affiliates increased by $21.1 million, or 22.1%, to $116.6 million for the year ended December 31, 2014 from $95.5 million for the year ended December 31, 2013. The increase in equity in earnings was primarily driven by acquisitions of $10.9 million.

Operating expenses, excluding depreciation and amortization, increased by $40.9 million, or 9.7%, to $461.7 million for the year ended December 31, 2014 from $420.7 million for the year ended December 31, 2013. The increase primarily represents the expenses of facilities we acquired during late 2013 and 2014 and additionally resulted from increased investment in general and administrative expenses related to deploying our strategic initiatives. We also recorded an impairment charge of $5.7 million related to four of our management contracts in 2014.

Depreciation and amortization decreased $1.2 million, or 4.5% to $26.0 million for the year ended December 31, 2014 from $27.2 million for the year ended December 31, 2013. Depreciation and amortization, as a percentage of revenues, was 4.1% for the year ended December 31, 2014 and 4.4% for the year ended December 31, 2013.

Operating income increased $6.0 million, or 2.3%, to $269.8 million for the year ended December 31, 2014 from $263.8 million for the year ended December 31, 2013, and decreased as a percentage of revenues to 42.1% from 42.8%, respectively. The increase in operating income was driven by the increases in net revenues and equity in earnings of unconsolidated affiliates described above, which was mostly offset by the increases in operating expense also discussed earlier. For the year ended December 31, 2014, operating income was also favorably impacted by EHR incentive income of approximately $3.2 million.

Interest expense, net of interest income, decreased $6.1 million, or 6.1%, to $93.7 million for the year ended December 31, 2014 from $99.8 million for the year ended December 31, 2013. The decrease is primarily due to fees we paid in February and March 2013 related to the refinancing we completed in April 2013.

Provision for income taxes was $37.5 million for the year ended December 31, 2014 as compared $31.4 million for the year ended December 31, 2013. Our effective tax rate for the years ended December 31, 2014 and 2013 was approximately 38% and 39%, respectively.

Total loss from discontinued operations was $0.3 million for the year ended December 31, 2014, and relates to the final disposal of fixed assets related to a previously sold entity.

Net income attributable to noncontrolling interests decreased $1.7 million, or 2.2%, to $77.1 million for the year ended December 31, 2014 from $78.8 million for the year ended December 31, 2013. Net income attributable to noncontrolling interests includes $1.1 million related to EHR incentive income recorded by our three consolidated hospitals during 2014.

Net income increased $11.1 million, or 8.7%, to $138.1 million for the year ended December 31, 2014 as compared to $127.1 million for the year ended December 31, 2013. Net income attributable to USPI's common stockholder increased $12.8 million, or 26.4%, to $61.0 million for the year ended December 31, 2014 as compared to $48.3 million for the year ended December 31, 2013.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

As discussed more fully in "Revenues," our consolidated revenues increased by $76.0 million, or 14.1%, to $616.2 million for the year ended December 31, 2013 from $540.2 million for the year ended December 31, 2012. The majority of the increase, approximately $68.7 million, was due to acquisitions.

Equity in earnings of unconsolidated affiliates decreased by $0.9 million, or 0.9%, to $95.5 million for the year ended December 31, 2013 from $96.4 million for the year ended December 31, 2012. The decrease in equity in earnings was primarily driven by the favorable impact of our share of an investee's gain on the sale of real estate ($2.4 million) in 2012, and our gaining control of three facilities that are now consolidated ($1.8 million). These decreases were partially offset by our $2.6 million share of EHR incentive income accrued by our equity method hospitals in 2013 and net increase related to the acquisition of equity method facilities in late 2012 and same-store facilities ($0.7 million).

Depreciation and amortization increased $3.2 million, or 13.7% to $27.2 million for the year ended December 31, 2013 from $24.0 million for the year ended December 31, 2012. Depreciation and amortization, as a percentage of revenues, was constant at 4.4% for both the years ended December 31, 2013 and December 31, 2012.

Operating income increased $18.6 million, or 7.6%, to $263.8 million for the year ended December 31, 2013 from $245.2 million for the year ended December 31, 2012, and decreased as a percentage of revenues to 42.8% from 45.4%, respectively. The increase in operating income was largely driven by acquisitions made in late 2012 as well as EHR incentive income recorded during 2013 of approximately $5.2 million. These increases offset the $1.7 million loss on the consolidation of a hospital and a $3.2 million impairment of a management contract. The decrease in operating income margin was driven by lower net revenue growth than we have historically experienced, and a payor mix shift to government versus commercial and a specialty mix shift.

Interest expense, net of interest income, increased $14.5 million, or 17.1%, to $99.8 million for the year ended December 31, 2013 from $85.3 million for the year ended December 31, 2012. The increase is due to higher overall debt balances at December 31, 2013 due to the refinancing we completed in April 2012 and additional borrowings in December 2012 and April 2013.

We incurred a loss on the early retirement of debt of $5.5 million during the year ended December 31, 2013, as a result of the repricing we completed in April 2013. The amount consists of finance and legal fees and the write-off of previously recorded debt issuance costs.

Provision for income taxes was $31.4 million for the year ended December 31, 2013 as compared $21.5 million for the year ended December 31, 2012. Our effective tax rates for the years ended December 31, 2013 and 2012 were approximately 39% and 44%, respectively.

Total income from discontinued operations was $3.1 million for the year ended December 31, 2012 On April 3, 2012, we spun-off our U.K. subsidiary to the equity holders of our Parent. As a result, the historical results of our U.K. operations are now classified as discontinued operations. The $3.1 million of income in 2012 is related to our U.K. operations before the spin-off.

Net income attributable to noncontrolling interests increased $6.1 million, or 8.4%, to $78.8 million for the year ended December 31, 2013 from $72.7 million for the year ended December 31, 2012. The increase was primarily driven by our gaining control of three facilities and acquiring an additional facility in 2013. Net income attributable to noncontrolling interests also includes $1.7 million related to EHR incentive income recorded by our three consolidated hospitals during 2013.

Net income increased $23.6 million to $127.1 million for the year ended December 31, 2013 as compared to $103.5 million for the year ended December 31, 2012. Net income (loss) attributable to USPI's common stockholder increased $17.5 million to a net income of $48.3 million for the year ended December 31, 2012 as compared to $30.8 million for the year ended December 31, 2012. The increase was due to the $38.0 million loss on early retirement of debt in 2012 and the 2013 earnings of acquired businesses, both of which were partially offset by higher interest expense in 2013.

Liquidity and Capital Resources

At December 31, 2014, we had cash and cash equivalents totaling $36.6 million, as compared to $78.7 million at December 31, 2013.

	Years Ended December 31,		
	2014	2013	2012
Net cash provided by operating activities	$ 211,558	$159,892	$ 180,313
Net cash used in investing activities	(145,243)	(64,741)	(160,907)
Net cash used in financing activities	(108,502)	(67,613)	(42,960)
Net cash provided by discontinued operations	—	—	32,935

Operating Activities

Our cash flows from operating activities were $211.6 million, $159.9 million, and $180.3 million in the years ended December 31, 2014, 2013, and 2012, respectively. Operating cash flows in 2014 increased $51.7 million, or 32.3%, as compared to 2013. The increase was primarily due to our increased earnings and the timing of distributions from our unconsolidated affiliates. Operating cash flows in 2013 decreased $20.4 million, or 11.3%, as compared to 2012. The decrease was primarily due to the timing of distributions from our facilities and increased interest expense due to higher debt balances after our April 2012 refinancing.

A significant element of our cash flows from operating activities is the collection of patient receivables and the timing of payments to our vendors and service providers. Collections efforts for patient receivables are conducted primarily by our personnel at each facility or in centralized service centers for some metropolitan

areas with multiple facilities. These collection efforts are facilitated by our patient accounting system, which prompts individual account follow-up through a series of phone calls and/or collection letters written 30 days after a procedure is billed and at 30 day intervals thereafter. Bad debt reserves are established in increasing percentages by aging category based on historical collection experience. Generally, the entire amount of all accounts remaining uncollected 180 days after the date of service are written off as bad debt and sent to an outside collection agency. Net amounts received from collection agencies are recorded as recoveries of bad debts. Our operating cash flows, including changes in accounts payable and other current liabilities, are impacted by the timing of payments to our vendors. We typically pay our vendors and service providers in accordance with invoice terms and conditions, and take advantage of invoice discounts when available. In 2014, 2013 and 2012, we did not make any significant changes to our payment timing to our vendors.

Our net working capital deficit was $124.5 million at December 31, 2014 as compared to a net working capital deficit of $102.4 million in the prior year. The overall negative working capital position at December 31, 2014 and 2013 is primarily the result of $159.6 million and $185.0 million due to affiliates associated with our cash management system being employed for our unconsolidated facilities. We hold our unconsolidated facilities' cash until these amounts are distributed to our partners, typically on a monthly or quarterly basis. As discussed further below, we have sufficient availability under our new credit agreement, together with our expected future operating cash flows, to service our obligations.

Investing Activities

During the years ended December 31, 2014, 2013 and 2012, respectively, our net cash used for investing activities was $145.2 million, $64.7 million and $160.9 million, respectively. The majority of the cash used in our investing activities relates to our purchases of businesses, incremental investment in unconsolidated affiliates and purchases of property and equipment. The cash used in investing activities was funded primarily from cash on hand as well as draws upon the revolving feature of our amended senior secured credit facility.

Acquisitions and Sales

During the year ended December 31, 2014, we invested $150.8 million, net of cash acquired, for the purchase and sales of businesses and investments in unconsolidated affiliates. These 2014 transactions are described earlier in this Item 7 under the captions "Acquisitions, Equity Investments and Development Projects" and "Discontinued Operations and Other Dispositions." These transactions are summarized below:

Effective Date	Facility Location	Amount
Investments		
October 2014	California	$ 10.2 million
October 2014	Texas	1.2 million
September 2014	Missouri	1.0 million
July 2014	New Jersey	26.8 million
July 2014	South Dakota	52.0 million
June 2014	Texas	4.2 million
April 2014	New Jersey	17.0 million
March 2014	Indiana	32.3 million
February 2014	Georgia	2.0 million
Various	Various	6.1 million
		152.8 million
Sales		
August 2014	Pennsylvania	$ (1.2 million)
June 2014	Florida	1.5 million
Various	Various	1.7 million
		2.0 million
Total		$ 150.8 million

During the years ended December 31, 2013 and 2012, we invested $43.0 million and $141.2 million (all net of cash acquired), respectively, to make similar acquisitions. These transactions are summarized in this Item 7 under the caption "Acquisitions, Equity Investments and Development Projects."

As part of our business strategy, we have made, and expect to continue to make, selective acquisitions in existing markets to leverage our existing knowledge of these markets and to improve operating efficiencies. Additionally, we may also make acquisitions in new markets. In making such acquisitions, we may use available cash on hand or draw upon our revolving credit facility as discussed below.

Property and Equipment/Facilities under Development

During the year ended December 31, 2014, we added $12.3 million in property and equipment, and an additional $7.1 million under capital lease arrangements. Approximately $4.1 million of the additions related to expansion and development projects, and the remaining $15.3 million primarily represents purchase of equipment at existing facilities. During the year ended December 31, 2013, we added $20.6 million in property and equipment, and an additional $1.8 million under capital lease arrangements. Approximately $11.1 million of the additiuns related to expansion and development projects, and the remaining $11.3 million primarily represents purchase of equipment at existing facilities. During 2012, we added $20.2 million in property and equipment, and an additional $10.5 million under capital lease arrangements. Approximately $17.5 million of the additions related to expansion and development projects, and the remaining $13.2 million primarily represents purchase of equipment at existing facilities.

Our growth strategy (through both acquisition and de novo projects) will continue to require substantial capital resources, which we estimate to range from $125.0 million to $150.0 million per year over the next three years. If we identify strategic opportunities that are larger than usual for us, then these amounts could increase.

Other than the specific transactions described above, our acquisition and development activities primarily include the development of new facilities, buyups of additional ownership in facilities we already operate, and acquisitions of additional facilities. In addition, the operations of our existing surgical facilities will require ongoing capital expenditures. The amount and timing of these purchases and related cash outflows in future periods is difficult to predict and is dependent on a number of factors including hiring of employees, the rate of change in technology/equipment used in our business and our business outlook. We expect to finance equipment primarily through internally generated funds and bank or manufacturer financing. We believe that our available capital is adequate to improve and equip our existing facilities.

The American Recovery and Reinvestment Act of 2009 ("ARRA") includes provisions to encourage healthcare providers to establish an electronic health record system ("EHR"), including cash incentives for qualifying hospitals and healthcare professionals who meet the criteria during the eligibility period of 2011 through 2016. By September 30, 2013, we had deployed a qualifying EHR at all fourteen of our eligible hospitals. Through the year ended December 31, 2014, we have incurred approximately $26.6 million of total costs to develop and deploy this technology. Of this amount, $3.1 million, $7.4 million and $11.8 million were capitalized in 2014, 2013 and 2012, respectively, and the remaining $4.3 million are classified within operating expenses. Our eligible hospitals, most of which are unconsolidated affiliates, received and then paid us approximately $3.4 million and $7.2 million in federal incentive payments during 2014 and 2013, respectively, which is reflected within our consolidated statements of cash flows as a reduction of capital expenditures.

If we maintain required definitions of meaningful use of EHR in 2015 and 2016, we expect to qualify for additional cash incentives each year. Based upon 2013 and 2014 utilization patterns at our facilities, the total cash incentives we receive for the years 2013 through 2016 would recover substantially all of our investment to date in EHR. Because the Centers for Medicare and Medicaid Services expanded the definition of meaningful use for 2014 and may do so again for future periods, we expect to incur additional costs to maintain our eligibility for federal incentive payments.

Financing Activities

Cash flows used in financing activities were $108.5 million, $67.6 million and $43.0 million in the years ended December 31, 2014, 2013 and 2012, respectively. Historically, our cash flows from financing activities have been received through proceeds from long-term debt and offset by payments on our long-term debt. We also manage the cash of our unconsolidated affiliates. During 2014, our financing activities included net payments un long-term debt of $4.3 million. Cash distributions to noncontrolling interests (the other investors in the facilities we operate) are also a large component of our financing activities and were $75.7 million, $76.0 million and $77.8 million in the years ended December 31, 2014, 2013 and 2012, respectively. Cash held on behalf of our unconsolidated affiliates decreased $25.8 million during the year ended December 31, 2014, but increased during the years ended December 31, 2013 and 2012 by $29.0 million and $17.8 million, respectively.

We intend to fund our ongoing capital and working capital requirements through a combination of cash flows from operations and borrowings under our $125.0 million revolving credit facility, under which we had $108.4 million available at December 31, 2014. We believe that funds generated by operations and funds available under the revolving credit facility will be sufficient to meet working capital requirements over at least the next 12 months. However, in the future, we may have to incur additional debt or issue additional debt or equity securities from time to time. We may be unable to obtain sufficient financing on satisfactory terms or at all.

We and our subsidiaries, affiliates (subject to certain limitations imposed by existing indebtedness), or significant stockholders, in their sole discretion, may from time to time, purchase, redeem, exchange or retire any of our outstanding debt in privately negotiated or open market purchases, or otherwise. Such transactions will depend on prevailing market conditions, our liquidity requirements, contractual restrictions and other factors.

Debt

In April 2012, we amended our existing credit facility. The amended credit facility provided borrowings consisting of $144.4 million in non-extended term loans which was to mature in April 2014; $312.4 million in extended term loans maturing in April 2017; $375.0 million in a new term loan maturing in April 2019; and $125.0 million under a new revolving facility maturing in April 2017. The term loans require quarterly principal payments of 0.25% of the outstanding balance as of April 3, 2012 with the remaining balances due in 2017 for the extended term loan and in 2019 for the new term loan. No principal payments are required on the revolving credit facility until its maturity in 2017. In December 2012, we borrowed an additional $150.0 million in new term loans under the amended credit facility. This borrowing requires quarterly principal payments of 0.25% of the outstanding balance and also matures in April 2019. We pay 0.50% per annum on the daily-unused commitment of the new revolving credit facility. We also pay a quarterly participation fee of 2.13% per annum related to outstanding letters of credit.

In February 2013, we further amended our credit facility and committed to borrow $150.0 million, which was used to repay the non-extended term loan of $144.4 million and related fees and expenses. The transaction was completed on April 4, 2013. The new term loan matures in April 2019. The amendment also changed the interest rate charged on the term loans to LIBOR plus a margin of 3.50% to 3.75%.

At December 31, 2014, we had $977.6 million outstanding under the amended credit facility at a weighted average interest rate of approximately 4.6%. At December 31, 2014, we had $108.4 million available for borrowing under the revolving credit facility, representing the revolving facility's $125.0 million capacity, net of the outstanding balance of $15.0 million and $1.6 million of outstanding letters of credit.

The amended credit facility is guaranteed by USPI Holdings, Inc. and its current and future directly and indirectly wholly-owned domestic subsidiaries, subject to certain exceptions, and borrowings under the credit facility are secured by a first priority security interest in all real and personal property of these subsidiaries, as well as a first priority pledge of our capital stock and the capital stock of each of our wholly owned domestic subsidiaries. Additionally, the credit facility contains various restrictive covenants, including financial covenants

that limit our ability and the ability of our subsidiaries to borrow money or guarantee other indebtedness, grant liens, make investments, sell assets, pay dividends, enter into sale-leaseback transactions or issue and sell capital stock. We believe we were in compliance with these covenants at December 31, 2014.

In April 2012, we issued $440.0 million of 9.0% senior unsecured notes due in April 2020. Interest on the notes is payable on April 1 and October 1 of each year, and commenced on October 1, 2012. At December 31, 2014, we had $440.0 million of the notes outstanding. The notes are unsecured senior obligations of our company; however, the notes are guaranteed by most of our current and future direct and indirect 100%-owned domestic subsidiaries. Additionally, the notes contain various restrictive covenants, including financial covenants that limit our ability and the ability of our subsidiaries to borrow money or guarantee other indebtedness, grant liens, make investments, sells assets, pay dividends, enter into sale-leaseback transactions or issue and sell capital stock. We believe we were in compliance with these covenants at December 31, 2014.

Contractual Cash Obligations

Our contractual cash obligations as of December 31, 2014 are summarized as follows:

	Payments Due by Period				
Contractual Cash Obligations	Total	Within 1 Year	Years 2 and 3	Years 4 and 5	Beyond 5 Years
			(In thousands)		
Long term debt obligations:					
Amended senior secured credit facility – new term loan(1)	$ 673,776	$ 6,705	$ 28,410	$638,661	$ —
Amended senior secured credit facility – extended term loan(1)	303,843	3,124	300,719	—	—
Senior unsecured notes (1)	440,000	—	—	—	440,000
Other debt at operating subsidiaries(1)	33,860	5,820	12,091	5,495	10,454
Interest on long-term debt obligations(2)	373,256	84,787	158,395	118,297	11,777
Capitalized lease obligations(3)	37,742	5,429	9,258	7,365	15,690
Operating lease obligations	95,491	18,516	32,199	23,950	20,826
Total contractual cash obligations	$1,957,968	$124,381	$541,072	$793,768	$498,747

(1) Scheduled principal payments.

(2) Represents interest due on long-term debt obligations. For variable rate debt, the interest is calculated using the December 31, 2014 rates applicable to each debt instrument.

(3) Includes principal and interest.

Debt at Operating Subsidiaries

Our operating subsidiaries, many of which have noncontrolling interest holders who share in the cash flow of these entities, have debt consisting primarily of capitalized lease obligations. This debt is generally non-recourse to USPI and is generally secured by the assets of those operating entities. The total amount of these obligations, which was $58.3 million at December 31, 2014, is included in our consolidated balance sheet because the borrower or obligated entity meets the requirements for consolidated financial reporting. Our average percentage ownership, weighted based on the individual subsidiary's amount of debt and capitalized lease obligations, of these consolidated subsidiaries was approximately 45% at December 31, 2014. As further discussed below, our unconsolidated affiliates that we account for under the equity method have debt and capitalized lease obligations that are generally non-recourse to USPI and are not included in our consolidated financial statements.

We believe that existing funds, cash flows from operations, borrowings under our credit facilities, and borrowings under capital lease arrangements at newly developed or acquired facilities will provide sufficient liquidity for the next twelve months. We may require additional debt or equity financing for our future

acquisitions and development projects. There are no assurances that needed capital will be available on acceptable terms, if at all. If we are unable to obtain funds when needed or on acceptable terms, we will be required to curtail our acquisition and development program.

Purchases and Sales of Noncontrolling Interests

During 2014, 2013 and 2012, we purchased and sold a net of $2.5 million, $1.6 million and $4.8 million of noncontrolling interests. Transactions with noncontrolling interests in which we do not lose control of an entity are classified as financing activities. These transactions represent equity transactions because they are between us (or our subsidiaries) and noncontrolling interests

Dividend Payments

On April 3, 2012 and December 17, 2012, we paid cash dividends of approximately $314.5 million and $69.9 million, respectively, to our Parent's equity holders.

Off-Balance Sheet Arrangements

As a result of our strategy of partnering with physicians and health systems, we do not own controlling interests in the majority of our facilities. We account for 156 of our 219 surgical facilities under the equity method. Similar to our consolidated facilities, our unconsolidated facilities have debts, including capitalized lease obligations, that are generally non-recourse to USPI. With respect to our unconsolidated facilities, these debts are not included in our consolidated financial statements. At December 31, 2014, the total debt on the balance sheets of our unconsolidated affiliates was approximately $356.2 million. Our average percentage ownership, weighted based on the individual affiliate's amount of debt, of these unconsolidated affiliates was approximately 26% at December 31, 2014. USPI or one of our wholly-owned subsidiaries had collectively guaranteed $20.8 million of the $356.2 million in total debt of our unconsolidated affiliates as of December 31, 2014. In addition, our unconsolidated affiliates have obligations under operating leases, of which we or a wholly owned subsidiary had guaranteed $8.3 million as of December 31, 2014. Of the total $29.1 million of guarantees related to unconsolidated affiliates, approximately $2.8 million represents guarantees of obligations of two facilities which have been sold. We have full recourse to the buyers with respect to the $2.8 million related to the sold facilities. Some of the facilities we are currently developing will be accounted for under the equity method. As these facilities become operational, they will have debt and lease obligations.

As described above, our unconsolidated affiliates own operational surgical facilities or surgical facilities that are under development. These entities are structured as limited partnerships, limited liability partnerships, or limited liability companies. None of these affiliates provide financing, liquidity, or market or credit risk support for us. They also do not engage in hedging, research and development services with us. Moreover, we do not believe that they expose us to any of their liabilities that are not otherwise reflected in our consolidated financial statements and related disclosures. Except as noted above with respect to guarantees, we are not obligated to fund losses or otherwise provide additional funding to these affiliates other than as we determine to be economically required in order to successfully implement our development plans.

Related Party Transactions

We have entered into agreements with certain majority and minority owned surgery centers to provide management services. As compensation for these services, the surgery centers are charged management fees which are either fixed in amount or represent a fixed percentage of each center's net revenue less bad debt. The percentages range from 3% to 8%. Amounts recognized under these agreements, after elimination of amounts from consolidated surgery centers, totaled approximately $80.6 million, $71.1 million, and $67.6 million in 2014, 2013, and 2012, respectively, and are included in management and contract service revenues in our consolidated statements of income.

We regularly engage in purchases and sales of ownership interests in our facilities. We operate 33 surgical facilities in partnership with Baylor Scott & White and local physicians in the Dallas/Fort Worth area. Baylor Scott & White Health's Chief Executive Officer is a member of our board of directors. The following table

summarizes transactions with Baylor Scott & White's during 2013. We had no such transactions in 2014 or 2012. We believe that the sale price was approximately the same as if it had been negotiated on an arms' length basis, and the price equaled the value assigned by an external appraiser who valued the business immediately prior to the sale.

Date	Facility Location	Proceeds	Gain
January 2013	Dallas, Texas(1)	$ 9.0 million	$ — million

(1) We contributed two surgery centers to a joint venture with Baylor Scott & White. We continue to account for these facilities under the equity method.

Included in general and administrative expenses are management fees payable to an affiliate of Welsh Carson, which holds a controlling interest in our company, in the amount of $2.0 million for the years ended December 31, 2014, 2013 and 2012. Such amounts accrue at an annual rate of $2.0 million. We pay $1.0 million in cash per year with the unpaid balance due and payable upon a change in control. At December 31, 2014, we had approximately $8.5 million accrued related to such management fee, of which $0.8 million is included in other current liabilities and $7.7 million is included in other long term liabilities in our consolidated balance sheet. At December 31, 2013, we had approximately $7.5 million accrued related to such management fee, of which $0.8 million is included in other current liabilities and $6.7 million is included in other long term liabilities in our consolidated balance sheet.

We have a revolving line of credit with European Surgical Partners Limited (ESP), a company owned in part by affiliates of Welsh Carson, members of USPI's management and other investors of up to $3.0 million. The balance owed to us by ESP was $2.5 million and $0.9 million at December 31, 2014 and 2013, respectively, and is included in "Other Assets" in the accompanying consolidated balance sheets. The borrowing bears interest at 6.5% per annum and matures upon the earlier of the refinance or discharge of ESP under its current third-party credit facility, at which time all principal and interest is due. We believe that the terms of the revolving line of credit are approximately the same as if they had been negotiated on an arms' length basis.

New Accounting Pronouncements

On May 28, 2014, the Financial Accounting Standards Board issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU), which requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. The ASU will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard is effective for our company on January 1, 2017. Early application is not permitted. The ASU permits the use of either the retrospective or cumulative effect transition method. We are evaluating the effect that the ASU will have on our consolidated financial statements and related disclosures. We have not yet selected a transition method nor have we determined the effect of the standard on our ongoing financial reporting.

On February 18, 2015, the FASB issued ASU No. 2015-02, *Consolidation (Topic 810): Amendments to the Consolidation Analysis* (ASU), which is intended to improve targeted areas of consolidation guidance for legal entities such as limited partnerships and limited liability companies among others. The ASU reduces the number of consolidation models from four to two and places more emphasis on the risk of loss when determining a controlling financial interest, reduces the frequency of the application of related-party guidance when determining a controlling financial interest in a variable interest entity and can change consolidation conclusions for companies that make use of limited partnerships or variable interest entities. The new standard is effective on January 1, 2016, however early adoption is permitted. We are evaluating the effect that the ASU may have on our consolidated financial statements and disclosures.

Item 7A. *Quantitative and Qualitative Disclosures about Market Risk*

Market risk represents the risk of loss that may impact our financial position, results of operations or cash flows due to adverse changes in interest rates and other relevant market risks. Our primary market risk is a

change in interest rates associated with variable-rate borrowings. Historically, we have not held or issued derivative financial instruments other than the use of variable-to-fixed interest rate swaps for portions of our borrowings under credit facilities with commercial lenders as required by credit agreements. Currently, we have no interest rate swaps in effect. We do not use derivative instruments for speculative purposes.

Our financing arrangements with many commercial lenders are based on the spread over LIBOR or Prime. At December 31, 2014, $473.9 million of our outstanding debt was in fixed rate instruments and the remaining $977.6 million was in variable rate instruments. Accordingly, a hypothetical 100 basis point increase in market interest rates would result in additional annual expense of approximately $9.8 million.

Item 8. ***Financial Statements and Supplementary Data***

For the financial statements and supplementary data required by this Item 8, see the Index to Consolidated Financial Statements included elsewhere in this Form 10-K.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

Evaluation of Disclosure Controls and Proeedures

We maintain disclosure controls and procedures that are designed to ensure that information required to be disclosed in our filings under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported within the periods specified in the rules and forms of the Commission. Such information is accumulated and communicated to our management, including the principal executive officer and principal financial officer, as appropriate, to allow timely decisions regarding required disclosure. As of the end of the period covered by this Annual Report on Form 10-K, we have carried out an evaluation, under the supervision and with the participation of management, including our principal executive officer and principal financial officer, of the effectiveness of the design and operation of our disclosure controls and procedures. Based upon that evaluation, the principal executive officer and principal financial officer concluded that, as of December 31, 2014, our disclosure controls and procedures are effective in timely alerting them to material information required to be included in our reports filed with the Commission. There have been no significant changes in our internal controls which could significantly affect the internal controls subsequent to the date of their evaluation in connection with the preparation of this Annual Report on Form 10-K.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Our internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

Our internal contrul over financial reporting includes those policies and procedures that:

- Pertain to the maintenance of records that in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets.
- Provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that our receipts and expenditures are being made only in accordance with authorizations of our management and board of directors; and
- Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on the financial statements.

Management assessed the effectiveness of our internal control over financial reporting as of December 31, 2014. In making this assessment, management used criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control — Integrated Framework—1992*. Management's assessment included an evaluation of the design and testing of the operational effectiveness of the Company's internal control over financial reporting. USPI acquired several subsidiaries and equity method investments during 2014. Accordingly, management's evaluation excluded the operations of the following subsidiaries and equity method investments acquired during 2014, with total assets of approximately $96.5 million and approximately $2.3 million of revenues included in the Company's consolidated financial statements as of December 31, 2014:

- USP Hazelwood, Inc.
- USP Morris, Inc.
- USP Siouxland, Inc.
- USP Sacramento, Inc. (Investment in Hacienda Outpatient Surgery Center, LLC)
- USP San Antonio, Inc. (Investment Alamo Heights Surgical Hospital Group, LP)

Based on this assessment, management did not identify any material weakness in the Company's internal control, and management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2014.

KPMG LLP, the independent registered public accounting firm that audited the Company's consolidated financial statements included in this report, has issued an attestation report on management's assessment of internal control over financial reporting, a copy of which is included with the Company's consolidated financial statements in Item 15(a)(1).

Limitations on the Effectiveness of Controls

Our management, including the principal executive officer and the principal financial officer, recognizes that any set of controls and procedures, no matter how well-designed and operated, can provide only reasonable, not absolute, assurance of achieving the desired control objectives. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, with the Company have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of controls. For these reasons, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting identified in connection with the evaluation described above that occurred during our last fiscal quarter that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. ***Other Information***

None.

PART III

ITEM 10. *Directors, Executive Officers and Corporate Governance*

Directors and Executive Officers

Executive officers of USPI are appointed annually by the board of directors and serve until their successors are duly elected and qualified. Directors are elected by USPI's stockholders and serve until their successors are duly elected and qualified. There are no arrangements or understandings between any officer or director and any other person pursuant to which any officer or director was, or is to be, selected as an officer, director, or nominee for officer or director. There are no family relationships among any of our executive officers or directors. The names, ages as of February 23 2015, and positions of the executive officers and directors of USPI are listed below along with their relevant business experience.

Name	Age	Position(s)
Paul B. Queally	50	Chairman of the Board
William H. Wilcox	63	Chief Executive Officer and Director
Brett P. Brodnax	50	President and Chief Development Officer
Jason B. Cagle	42	Senior Vice President and Chief Financial Officer
Philip A. Spencer	45	Executive Vice President, Business Development
Sandra R.A. Karrmann	49	Senior Vice President and Chief Human Resources and Support Services Officer
Joel T. Allison	67	Director
Anthony F. Ecock	53	Director
John C. Garrett, M.D.	72	Director
D. Scott Mackesy	46	Director
James Ken Newman	71	Director
Harold L. Paz, M.D., M.S.	60	Director
Raymond A. Ranelli	67	Director

Paul B. Queally has served as a director of USPI since its inception in February 1998 and serves as the chairman of the compensation committee and a member of the executive committee. Mr. Queally is Co-President of Welsh, Carson, Anderson & Stowe, where he focuses primarily on investments in the healthcare industry and is a managing member of the general partner of Welsh, Carson, Anderson & Stowe IX, L.P. Prior to joining Welsh Carson in 1996, Mr. Queally was a general partner at the Sprout Group, the private equity group of the former Donaldson, Lufkin & Jenrette. He is a member of the boards of directors of AGA Medical Corporation, Aptuit, Inc. and several private companies. Mr. Queally's service on the boards of multiple private and public companies and his extensive experience in corporate transactions, including mergers and acquisitions, leveraged buyouts and private equity financing, provide the board with an important perspective in making strategic decisions.

William H. Wilcox joined USPI as its president and a director in September 1998. Mr. Wilcox has served as USPI's chief executive officer since April 2004 and is a member of the executive committee. Mr. Wilcox served as president and chief executive officer of United Dental Care, Inc. from 1996 until joining USPI. Mr. Wilcox served as president of the Surgery Group of HCA and president and chief executive officer of the Ambulatory Surgery Division of HCA from 1994 until 1996. Prior to that time, Mr. Wilcox also previously served as the chief operating officer and a director of Medical Care International, Inc. Mr. Wilcox, through his intimate knowledge of the operational, financial and strategic development of USPI and his experience in the healthcare industry, provides the board with a valuable perspective into the opportunities and challenges facing the Company.

Brett P. Brodnax serves as the president and chief development officer of USPI. Prior to joining USPI in December 1999, Mr. Brodnax was an assistant vice president of the Baylor Health Care System and worked for them from 1990 until 1999. Mr. Brodnax currently serves as a director of K2M, Inc. and also served as a director of AmeriPath, Inc. from January 2005 until May 2007.

Jason B. Cagle serves as the senior vice president and chief financial officer of USPI. Prior to joining USPI, Jason was an attorney with Vinson & Elkins, LLP, where he worked in the corporate section. Before his promotion to chief financial officer, Jason was USPI's General Counsel from 2003 to 2012 and its Senior Vice President of Acquisitions from 2012 to 2013.

Philip A. Spencer joined USPI in July 2009. From November 2006 until joining USPI, Mr. Spencer served as President, Anatomic Pathology Services for AmeriPath, Inc. From November 2003 to November 2006, he served as Executive Vice President of Healthcare Sales and Marketing for LabOne, Inc. From December 2000 to November 2003, Mr. Spencer served as Vice President, Business Development for Laboratory Corporation of America.

Sandra R.A. Korrmonn joined USPI as the senior vice president, chief human resources officer and support services officer in January 2013. Prior to joining USPI, Ms. Karrmann served in various leadership positions in human resources with Yum! Brands, Inc. from August 2007 until December 2012, including serving as the chief people officer of Yum! Restaurants International from March 2009 until January 2012 and chief people officer of Pizza Hut from August 2007 until March 2009. Prior to that time, Ms. Karrmann served as the executive vice president, chief human resources officer of Meritage Homes Corporation and held various leadership positions in human resources with Pepsico, Inc./Frito-Lay, Inc., Heller Financial, Inc. and Macy & Company, Inc.

Joel T. Allison has served on our board since March 2002. Mr. Allison has served as chief executive officer of Baylor Scott & White Health since Baylor Healthcare System (Baylor) and Scott & White entered into an affiliation and merger of governance af their healthcare systems effective October 1, 2013. Mr. Allison has also served as chief executive officer of Baylor since 2000, president of Baylor from 2000 until October 1, 2013, and senior executive vice president of Baylor from 1993 until 2000. Mr. Allison brings an important perspective to the board through his role in leading a major healthcare system and his familiarity with issues impacting physicians and the delivery of healthcare in the U.S.

Anthony F. Ecock joined our board in May 2013. Mr. Ecock is currently a general partner at Welsh, Carson, Anderson & Stowe, which he joined in 2007. He has over 25 years of experience in the healthcare field with eight years in senior management positions at leading healthcare technology companies. At WCAS, Mr. Ecock leads the Resources Group, a team responsible for helping its 30 portfolio companies identify and implement initiatives to increase growth, earnings and cash flow. Before joining WCAS, he served as Vice President and General Manager of GE Healthcare's Enterprise Sales organization from 2003 to 2007. From 1999 to 2003, he served as Senior Vice President and Global General Manager of Hewlett Packard's, then Agilent's and finally Philips' Patient Monitoring divisions. Mr. Ecock spent his early career at the consulting firm of Bain & Company, where he was a Partner in the healthcare and technology practices and Program Director for Consultant Training.

John C. Gorrett, M.D. has served on our board since February 2001 and is a member of the audit and compliance committee. Dr. Garrett had been a director of OrthoLink Physicians Corporation, which was acquired by USPI in February 2001, since July 1997. Dr. Garrett founded Resurgens, P.C. in 1986, where he maintained a specialized orthopedics practice in arthroscopic and reconstructive knee surgery until his retirement in 2007. Dr. Garrett is a Fellow of the American Academy of Orthopedic Surgeons. The board benefits from Dr. Garrett's knowledge of clinical and regulatory issues impacting our facilities and physician partners and his familiarity with USPI with which he has served as a director since 2001.

D. Scott Mackesy joined our board, executive committee and compensation committee in April 2007. Mr. Mackesy is a general partner of Welsh, Carson, Anderson & Stowe, where he focuses primarily on investments in the healthcare industry and is a managing member of the general partner of Welsh, Carson, Anderson & Stowe X, L.P. Prior to joining Welsh Carson, Mr. Mackesy was a research analyst at Morgan Stanley, where he was responsible for coverage of the healthcare services industry. He is a member of the board of directors of several private companies. Mr. Mackesy, through his lengthy and broad focus on the healthcare industry, offers the board greater insight into industry dynamics as well as investment and acquisition strategies.

James Ken Newman has served on our board since May 2005 and is a member of the audit and compliance committee. Mr. Newman served as president and chief executive officer of Horizon Health Corporation from May 2003 until its sale in June 2007 and as chairman of the board from February 1992 until June 2007. From July 1989 until September 1997, he served as president of Horizon Health and from July 1989 until October 1998, he also served as chief executive officer of Horizon Health. Mr. Newman is a member of the board of directors of Telecare Corporation and Springstone, Inc. Mr. Newman's leadership and experience in the healthcare industry helps the board better assess the challenges and opportunities facing USPI.

Harold L. Paz, M.D., M.S., joined our board in February 2014. Dr. Paz has served as chief executive officer of Penn State Hershey Medical Center and Health System, senior vice president for health affairs for Penn State University and dean of its College of Medicine since April 2006. Prior to his appointment to Penn State, he served as dean of the Robert Wood Johnson Medical School and chief executive officer of Robert Wood Johnson University Medical Group in New Jersey for eleven years, where he was professor of medicine. Dr. Paz brings an important perspective to the board through his role in leading a major healthcare system and his familiarity with issues impacting physicians.

Raymond A. Ranelli joined our board in May 2007 and serves as the chairman of the audit and compliance committee. Mr. Ranelli retired from PricewaterhouseCoopers in 2003 where he was a partner for over 20 years. Mr. Ranelli held several positions at PricewaterhouseCoopers including Vice Chairman and Global Leader of the Financial Advisory Services practice. Mr. Ranelli is also a director of Syniverse Technologies, Inc., K2M, Inc. and several private companies. Mr. Ranelli possesses in-depth, practical knowledge of financial and accounting principles, having served in the financial services sector for over 20 years and serving on other boards and committees. This background, along with his past experience as a certified public accountant, is important to his role as chairman of the audit and compliance committee.

Audit Committee Financial Expert

Our board has determined that Raymond A. Ranelli, a director and chairman of the audit and compliance committee, is a financial expert and is independent as that term is used in the rules of the National Association of Securities Dealers' listing standards ("NASDAQ Rules").

Nominations for the Board of Directors

Our board of directors does not have a separately designated, standing nominating committee, a nominating committee charter, or a formal procedure for security holders to recommend nominees to the board of directors. USPI is not listed on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, and we are not subject to either the listing standards of the New York Stock Exchange or the NASDAQ Rules.

Section 16(a) Beneficial Ownership Reporting Compliance

USPI does not have any class of equity securities registered under Section 12 of the Exchange Act. Consequently, Section 16(a) of the Exchange Act is not applicable.

Code of Ethics

We have adopted a Code of Conduct and a Financial Code of Ethics both applicable to our principal executive officer, principal financial officer, principal accounting officer or controller, or other persons performing similar functions. Copies of the Code of Conduct and the Financial Code of Ethics may be obtained, free of charge, by writing to the secretary of the Company at: United Surgical Partners International, Inc., 15305 Dallas Parkway, Suite 1600, Addison, Texas 75001.

Item 11. *Executive Compensation*

Overview

This compensation discussion and analysis describes the material elements of compensation awarded to named executive officers for our 2014 fiscal year. It should be read in conjunction with the Summary Compensation Table, related tables and the narrative disclosure. Unless otherwise specifically noted, the information contained in this section is stated as of December 31, 2014.

The compensation committee of our board of directors makes decisions regarding salaries, annual bonuses and equity incentive compensation for our named executive officers. Our named executive officers include our chief executive officer, our chief financial officer and our three most highly compensated executive officers other than our chief executive officer and chief financial officer. The compensation committee is also responsible for reviewing and approving corporate goals and objectives relevant to the compensation of our named executive officers, as well as evaluating their performance in light of those goals and objectives. Based on this evaluation, the compensation committee determines and approves the named executive officers' compensation. The compensation committee solicits input from our chief executive officer regarding the performance of the company's other named executive officers. Finally, the compensation committee also administers our equity incentive plan.

The chief executive officer reviews our compensation plan. Based on his analysis, the chief executive officer recommends a level of compensation to the compensation committee, other than for himself, which he views as appropriate to attract, retain and motivate executive talent. The compensation committee determines and approves the chief executive officer's and other named executive officers' compensation.

Our Compensation Philosophy and Objectives

We have sought to create an executive compensation program that balances short-term versus long-term payments and awards, cash payments versus equity awards and fixed versus contingent payments and awards in ways that we believe are most appropriate to motivate our executive officers. Our executive compensation program is designed to:

- attract and retain superior executive talent in the healthcare industry;
- motivate and reward executives to achieve optimum short-term and long-term corporate operating results;
- align the interests of our executive officers and stockholders by motivating executive officers to increase stockholder value; and
- provide a compensation package that recognizes individual contributions as well as overall business results.

In determining each component of, and the overall, compensation of our named executive officers, the compensation committee does not exclusively use quantitative methods or formulas, but instead considers various factors, including the position of the named executive officer, the compensation of officers of comparable companies within the healthcare industry, the performance of the named executive officer with respect to specific objectives, increases in responsibilities, recommendations of the chief executive officer and other objective and subjective criteria as the compensation committee deems appropriate. The specific objectives for each named executive officer vary each year in accordance with the scope of the officer's position, the potential inherent in that position for impacting the Company's operating and financial results and the actual operating and financial contributions produced by the officer in previous years.

Compensation Components

Our compensation consists primarily of three elements: base salary, annual bonus and long-term equity incentives. We describe each element of compensation in more detail below.

Base Salary

Base salaries for our named executive officers are established based on the scope of their responsibilities and their prior relevant experience, taking into account competitive market compensation paid by other companies in our industry for similar positions and the overall market demand for such executives at the time of hire. A named executive officer's base salary is also determined by reviewing the executive's other compensation to ensure that the executive's total compensation is in line with our overall compensation philosophy. Base salaries are reviewed annually and may be increased for merit reasons, based on the executive's success in meeting or exceeding individual performance objectives. Additionally, we may adjust base salaries as warranted throughout the year for promotions or other changes in the scope or breadth of an executive's role or responsibilities. Based on these factors base salaries for our named executive officers were set as follows effective August 1, 2014: $650,000 for Mr. Wilcox, $600,000 for Mr. Brodnax, $400,000 for Mr. Cagle, $390,000 for Ms. Karmann and $390,000 for Mr. Spencer.

Annual Bonus

Our compensation program includes eligibility for an annual incentive cash bonus. The compensation committee assesses the level of the named executive officer's achievement of meeting individual goals, as well as that officer's contribution towards our long-term, Company-wide goals. The amount of the cash bonus depends primarily on the Company meeting budgeted EBITDA goals, with a target bonus for each named executive officer generally set as a percentage of base salary. Target bonuses for the named executive officers were set at the following percentages of base salary for 2014, 52% for Mr. Wilcox, 42% for Mr. Brodnax, 36% for Messrs. Spencer and Cagle and 33% for Ms. Karmann. Based on the Company's EBITDA performance compared to budget in 2014, the named executive officers received bonuses equal to the following percentages of their base salary for 2014: 47% for Mr. Wilcox (excluding discretionary contributions to the deferred compensation plan), 32% for Mr. Brodnax, 25% for Mr. Spencer, 38% for Mr. Cagle and 28% for Ms. Karmann.

EBITDA is not a measure defined under GAAP. The Company believes EBITDA is an important measure for purposes of assessing performance. EBITDA, which is computed by adding operating income plus depreciation and amortization and losses on deconsolidations, disposals and impairments, is commonly used as an analytical indicator within the healthcare industry and also serves as a measure of leverage capacity and debt service ability. EBITDA should not be considered as measures of financial performance under GAAP and EBITDA targets and the Company's achievement of such targets should not be understood as management's prediction of future performance or guidance to investors.

Long-Term Equity Incentives

We believe that equity-based awards allow us to reward named executive officers for their sustained contributions to the Company. We also believe that equity awards reward continued employment by a named executive officer, with an associated benefit to us of employee continuity and retention. We believe that equity awards provide management with a strong link to long-term corporate performance and the creation of stockholder value. The compensation committee has the authority to grant shares of restricted stock and options to purchase shares of certain classes of common and preferred equity securities of our Parent. The compensation committee does not award equity awards according to a prescribed formula or target. Instead, the compensation committee takes into account the individual's position, scope of responsibility, ability to affect profits and the individual's historic and recent performance and the value of the awards in relation to other elements of the individual executive's total compensation. Effective July 15, 2014, Mr. Cagle and Ms. Karmann were granted

options to purchase 300,000 shares of the Company's common stock and Mr. Spencer was granted options to purchase 200,000 shares of the Company's common stock. These options vest ratably over four years and have an exercise price of $2.00 per share, equal to the compensation committee's estimate of fair value on the date of grant. No other equity awards were granted to the Company's named executive officers in 2014. For a further description of the Company's equity-based plan, see "Restricted Stock and Option Plan" below.

Termination Based Compensation

For payments due to our named executive officers upon termination, and the acceleration of vesting of equity-based awards in the event of a change of control under our new equity plan, see "Restricted Stock and Option Plan" and "Employment Arrangements and Agreements" below.

Other Benefits and Perquisites

We provide health and welfare benefits to our named executive officers that are available to all of the Company's employees. Included in these benefits is a 401(k) plan that we maintain because we wish to encourage our employees to save a percentage of their cash compensation, through voluntary deferrals, for their eventual retirement. We match fifty percent of the first six percent of cash compensation contributed by individual employees subject to IRS limitations.

We also make available to our named executive officers certain perquisites and other benefits that we believe are reasonable and consistent with the perquisites that would be available to them at companies with whom we compete for experienced senior management. The primary perquisite we currently provide to named executive officers as well as certain other select members of the management team is access to a Deferred Compensation Plan ("DCP") through which the individuals can voluntarily defer up to 75% of their base salary and 100% of their bonus. We match fifty percent of the first ten percent of compensation voluntarily deferred under this plan. Additionally, in 2014 we contributed $200,000 to Mr. Wilcox's DCP account.

Compensation Committee Report

The compensation committee of USPI has reviewed and discussed the Compensation Discussion and Analysis required by Item 402(b) of Regulation S-K with management and, based on such review and discussions, the compensation committee has recommended to the board of directors that the Compensation Discussion and Analysis be included in this Annual Report on Form 10-K.

The Compensation Committee

Paul B. Queally, Chairman
D. Scott Mackesy

Summary Compensation Table for 2014

The following table sets forth the total remuneration paid by us for each of the last three fiscal years to the named executive officers.

Name and Principal Position	Year	Salary	Bonus	Stock Awards(1)	Option Awards(1)	Non-Equity Incentive Plan Compensation	Change in Nonqualified Deferred Compensation Earnings	All Other Compensation	Total
William H. Wilcox	2014	$650,000	$303,608(2)	$ —	$ —	$ —	$ 167,748	$ 245,591(3)	$1,366,947
Chief Executive Officer	2013	643,750	101,810(2)	—	—	—	218,756	247,066(3)	1,211,382
and Director	2012	630,823	138,577(2)	—	—	—	160,687	7,896,292(3)	8,826,379
Brett P. Brodnax	2014	570,833	184,492(2)	—	—	—	19,440	36,967(3)	811,732
President and	2013	543,750	92,724(2)	—	—	—	57,434	41,109(3)	735,017
Chief Development Officer	2012	530,833	120,421(2)	—	—	—	43,243	3,102,542(3)	3,797,039
Jason B. Cagle	2014	385,417	145,307(2)	—	243,000	—	12,005	31,471(3)	817,200
Senior Vice President and	2013	358,333	82,739(2)	—	449,500	—	29,995	28,437(3)	949,004
Chief Financial Officer									
Philip A. Spencer	2014	368,417	91,103(2)	—	162,000	—	14,034	11,716(4)	647,270
Executive Vice President,	2013	350,083	72,321(2)	—	124,000	—	21,490	30,043(4)	597,937
Business Development	2012	343,500	91,779	—	—	—	11,209	832,175(4)	1,278,663
Sandra R.A. Kammann	2014	352,083	100,000(2)	—	243,000	—	—	7,905(3)	702,988
Senior Vice President and	2013	320,208	100,000(2)	—	186,000	—	—	8,131(3)	614,339
Chief Human Resources and Support Services Officer									

(1) We account for the cost of stock-based and option-based compensation awarded under the 2007 Equity Incentive Plan adopted by our Parent under which the cost of equity awards to employees is measured by the aggregate grant date fair value of the awards on their grant date calculated in accordance with the FASB's *Accounting Standards* Codification Topic 718. No forfeitures occurred during 2012, 2013 or 2014. Assumptions used in calculation of these amounts are included in Note 13 to our consolidated audited financial statements for the fiscal year ended December 31, 2014, included in this Annual Report on Form 10-K.

(2) Ninety percent of the amount shown was paid in cash and ten percent was deferred at our named executive officer's election pursuant to USPI's Deferred Compensation Plan (the "DCP").

(3) Includes cash dividends paid on stock awards held by each named executive officer and discretionary contributions to the named executive officers' DCP, matching contributions to the named executive officers' DCP and 401(k) accounts and cash incentives for participation in the Company's wellness program as follows:

	Cash Dividends on Stock Awards	Discretionary Contribution to DCP	Matching Contribution 401(k)	Matching Contribution DCP	Wellness Program Incentive
Mr. Wilcox					
2014	$ —	$ 200,000	$ 7,800	$ 37,591	$ 200
2013	—	$ 200,000	$ 7,650	$ 39,116	$ 300
2012	7,657,250	200,000	7,500	31,542	—
Mr. Brodnax					
2014	—	—	7,800	29,167	—
2013	—	—	7,650	33,209	250
2012	3,068,500	—	7,500	26,542	—
Mr. Cagle					
2014	—	—	7,800	23,471	200
2013			7,650	20,787	—
Mr. Spencer					
2014	—		7,800	3,616	300
2013	—	—	7,650	22,093	300
2012	807,500	—	7,500	17,175	—
Ms. Karmann					
2014	—	—	7,505	—	400
2013	—	—	7,531		600

Grant of Plan-Based Awards

The following table shows the plan-based awards granted to the named executive officers during 2014.

Name	Grant Date	All Other Options Awards: Number of Securities Underlying Options	Exercise or Base Price of Option Awards	Grant Date Fair Value of Stock and Option Awards
William H. Wilcox	—	—	—	—
Brett P. Brodnax	—	—	—	—
Jason B. Cagle	7/15/2014	300,000	$ 2.00	$ 243,000
Philip A. Spencer	7/15/2014	200,000	2.00	162,000
Sandra R.A. Karmann	7/15/2014	300,000	2.00	243,000

Outstanding Equity Awards at Fiscal Year-End

The following table shows all outstanding equity awards held by our named executive officers as of December 31, 2014.

		Option Awards				Stock Awards	
Name	Grant Date	Number of Securities Underlying Unexercised Options (Exercisable)	Number of Securities Underlying Unexercised Options (Unexercisable)	Option Exercise Price	Option Expiration Date	Number of Shares that have not Vested	Fair Value of Shares that have not Vested(6)
William H. Wilcox	4/19/2007(1)	—	—	—	—	2,375,000(7)	$ 5,106,250
	4/19/2007(1)	—	—	—	—	496,536(8)	1,067,552
Brett P. Brodnax	4/19/2007(1)	—	—	—	—	950,000(7)	2,042,500
	4/19/2007(1)	—	—	—	—	275,853(8)	593,084
	6/1/2011(2)	750,000	250,000	$ 0.29	6/1/2019	—	—
Jason B. Cagle	4/19/2007(1)	—	—	—	—	87,500(7)	188,125
	6/1/2011(2)	75,000	25,000	0.29	6/1/2019	—	—
	3/1/2013(3)	181,250	543,750	1.59	3/1/2021	—	—
	7/15/2014(4)	—	300,000	2.00	7/15/2022	—	—
Philip A. Spencer	8/28/2009(5)	—	—	—	—	250,000(7)	537,500
	3/1/2013(3)	50,000	150,000	1.59	3/1/2021	—	—
	7/15/2014(4)	—	200,000	2.00	7/15/2022	—	—
Sandra R.A. Karrmann	3/1/2013(3)	75,000	225,000	1.59	3/1/2021	—	—
	7/15/2014(4)	—	300,000	2.00	7/15/2022	—	—

(1) Upon consummation of the merger, our named executive officers received new stock awards under the 2007 Equity Incentive Plan.

(2) Mr. Brodnax and Mr. Cagle received option awards under the 2007 Equity Incentive Plan in connection with promotions. In connection with the dividends declared on the Company's stock in 2012, the exercise price on these options was reduced to $0.29 during 2012.

(3) Messrs. Cagle and Spencer and Ms. Karrmann received option awards under the 2007 Equity Incentive Plan in connection with a promotion to Chief Financial Officer for Mr. Cagle, assumption of additional responsibilities for Mr. Spencer and as an initial equity grant upon joining USPI for Ms. Karrmann.

(4) Messrs. Cagle and Spencer and Ms. Karrmann received option awards under the 2007 Equity Incentive Plan.

(5) Mr. Spencer received a stock award upon joining the Company.

(6) Because there is no active trading market for our common stock, we rely on members of the compensation committee and Welsh Carson to determine in good faith the fair value of our common stock. As of December 31, 2014, this value was determined to be $2.15 per share of common stock. Neither USPI, USPI Holdings, Inc. nor USPI Group Holdings, Inc. has any class of equity securities registered under Section 12 of the Exchange Act.

(7) The restrictions with respect to these shares will lapse on April 19, 2015; provided however, that such restrictions may lapse sooner if certain internal rate of return targets are met.

(8) The restrictions with respect to such shares will lapse upon a change of control or other exit event provided that Welsh Carson shall have disposed of all of its shares of our Parent acquired in connection with the merger and received its cost basis in such shares plus a return of at least 100%.

Option Exercises and Stock Values

The following table shows all stock options exercised during 2014 and the value realized upon exercise, and all stock awards vested during 2014 and the value realized upon vesting.

	Option Awards		Stock Awards	
Name	Number of Shares Acquired on Exercise	Value Realized on Exercise	Number of Shares Acquired on Vesting	Value Realized on Vesting
William H. Wilcox	N/A	$ —	—	$ —
Brett P. Brodnax	N/A	—	—	—
Jason B. Cagle	N/A	—	—	—
Philip A. Spencer	N/A	—	—	—
Sandra R.A. Kammann	N/A	—	—	—

Restricted Stock and Option Plan

Our Parent adopted the 2007 Equity Incentive Plan which became effective contemporaneously with the consummation of the merger, which we sometimes refer to as the equity plan. The purposes of the equity plan are to attract and retain the best available personnel, provide additional incentives to our employees, directors and consultants and to promote the success of our business. A maximum of 31,816,215 shares of common stock may be delivered in satisfaction of awards made under the equity plan.

The compensation committee administers the equity plan (the "Administrator"). Participation in the plan is limited to those key employees and directors, as well as consultants and advisors, who in the Administrator's opinion are in a position to make a significant contribution to the success of USPI and its affiliated corporations and who are selected by the Administrator to receive an award. The plan provides for awards of stock appreciation rights ("SARs"), stock options, restricted stock, unrestricted stock, stock units, including restricted stock units, and performance awards pursuant to the Administrator's discretion and the provisions set forth in the plan. Eligibility for incentive stock options ("ISOs") is limited to employees of USPI or of a "parent corporation" or "subsidiary corporation" of USPI as those terms are defined in Section 424 of the United States Internal Revenue Code of 1986, as amended. Each option granted pursuant to the plan will be treated as providing by its terms that it is to be a non-incentive stock option unless, as of the date of grant, it is expressly designated as an ISO.

The exercise price of each stock option and the share value above which appreciation is to be measured in the case of a SAR will be 100% of the fair value of the stock subject to the stock option or SAR, determined as of the date of grant, or such higher amount as the Administrator may determine in connection with the grant.

Neither ISOs nor, except as the Administrator otherwise expressly provides, other awards may be transferred other than by will or by the laws of descent and distribution. During a recipient's lifetime an ISO and, except as the Administrator may provide, other non-transferable awards requiring exercise may be exercised only by the recipient. Awards permitted by the Administrator to be transferred may be transferred only to a permitted transferee.

No awards may be made after April 18, 2017, but previously granted awards may continue beyond that date in accordance with their terms. The Administrator may at any time amend the equity plan or any outstanding award for any purpose which may at the time be permitted by law, and may at any time terminate the equity plan as to any future grants of awards; provided, that except as otherwise expressly provided in the plan, the Administrator may not, without the participant's consent, alter the terms of an award so as to affect adversely the participant's right under the award, unless the Administrator expressly reserved the right to do so at the time of the award.

Upon termination of a named executive officer's employment for any reason (including, without limitation, as a result of death, disability, incapacity, retirement, resignation, or dismissal with or without cause), then any vested shares as of the date of such termination shall remain vested shares, and no additional shares will become vested after the date of such termination, except if otherwise determined by the Administrator or within 180 days after the executive's termination, USPI consummates a change of control, in which case, the provisions pertaining to a change of control will apply.

The restricted shares acquired under the equity plan shall vest in full upon a change of control if, as a result of such change of control, Welsh Carson shall have disposed of all of the investor shares and received its cost basis in its investor shares plus an investor return of at least 100%. In the event the shares do not vest on such change of control, such shares shall be forfeited upon the closing of such change of control.

Nonqualified Deferred Compensation

The following table shows certain information regarding the named executive officers' DCP accounts as of December 31, 2014.

	2014 Activity				
Name	Executive Contribution	USPI Contribution	Aggregate Earnings	Aggregate Withdrawals/ Distributions	Aggregate Balance at December 31, 2014
William H. Wilcox	$ 75,181	$ 237,591	$167,748	$ 94,941	$3,732,687
Brett P. Brodnax	58,333	29,167	19,440	—	554,661
Jason B. Cagle	46,941	23,470	12,005	—	339,698
Philip A. Spencer	7,232	3,616	14,034	44,560	208,365
Sandra R. Karrmann	—	—	—	—	—

Deferred Compensation Plan

USPI has a deferred compensation plan that certain of its directors, executive officers and other employees participate in which allows such participants to defer a portion of their compensation to be paid upon certain specified events (including death, termination of employment, disability or some future date). Under the terms of the DCP, all amounts payable under the DCP would become immediately vested in connection with a change of control of USPI, and as a result, each participant would be entitled to be paid their full account balance upon consummation of such a transaction. Notwithstanding the foregoing, USPI amended the DCP to exclude the merger from the definition of a change of control for purposes of the DCP. As a result, the merger had no effect on the vesting of the account balance of any participant in the deferred compensation plan.

Our board of directors designates those persons who are eligible to participate in the DCP. Currently, each of Messrs. Wilcox, Brodnax, Spencer and Cagle, and Ms. Karrmann are eligible to participate in the DCP. The DCP enables participants to defer all or a portion of their bonus in a calendar year and up to 75% of their base salary, typically by making a deferral election in the calendar year prior to the year in which the bonus relates or the annual salary is otherwise payable.

Although participants are 100% vested in their deferrals of salary and bonus, USPI contributions to the DCP are subject to vesting schedules established by the compensation committee in its sole discretion (which may vary among different contributions). Notwithstanding such vesting schedules, participants will become 100% vested in their accounts under the DCP in the event of (i) retirement on or after the earlier to occur of (a) age 60 following the completion of five years of service with USPI or (b) age 65, (ii) a change in control or (iii) death.

Benefits are payable upon termination of employment. Participants may also elect, at the time they make an annual deferral, to receive a lump sum in-service distribution payable in a calendar year that is three or more years after the calendar year to which the deferral is related. A participant who elects an in-service distribution may defer the distribution for an additional five years from the original payment date so long as such election is

made at least 12 months prior to the original payment date. Participants may also make an in-service withdrawal from the DCP on account of an unforeseeable emergency (as defined in the DCP). Amounts under the DCP are distributed in a lump sum cash payment, except as provided below, unless the distribution is on account of retirement at normal retirement age under the DCP. A participant can elect, at the time of a deferral under the DCP, to receive his retirement benefit in either a lump sum or pursuant to annual installments over five, 10 or 15 years. Participants may change the form of payment of their retirement benefit from a lump sum to an annual installment payment, provided such election is submitted one year prior to the participant's retirement.

A participant's account will be credited with earnings and losses based on returns on deemed investment options selected by the participant from a group of deemed investments established by the deferred compensation plan committee.

USPI may make a discretionary contribution on behalf of any or all participants depending upon the financial strength of USPI. The amount of the contribution, if any, is determined in the sole discretion of the compensation committee. Currently, USPI matches fifty percent of any deferral by a named executive officer, subject to a total cap on the matching contribution of five percent of the officer's compensation.

The DCP is administered by USPI's compensation committee. The DCP is an "unfunded" arrangement for purposes of ERISA. Accordingly, the DCP consists of a mere promise by USPI to make payments in accordance with the terms of the DCP and participants and beneficiaries have the status of general unsecured creditors of USPI. A participant's account and benefits payable under the DCP are not assignable. USPI may amend or terminate the DCP provided that no amendment adversely affects the rights of any participant with respect to amounts that have been credited to his account under the DCP prior to the date of such amendment. Upon termination of the DCP, a participant's account will be paid out as though the participant experienced a termination of employment on the date of the DCP's termination or, for participants who have attained normal retirement age, in the form of payment elected by the participant.

Employment Arrangements and Agreements

Set forth below is a description of our employment agreements and other compensation arrangements with our named executive officers.

We have employment agreements with William H. Wilcox as Chief Executive Officer, Brett P. Brodnax as President and Chief Development Officer, Jason B. Cagle as Senior Vice President and Chief Financial Officer, Philip A. Spencer as Executive Vice President, Business Development and Sandra R.A. Karmann as Senior Vice President and Chief Human Resources and Support Services Officer

The initial term of our employment agreement with William H. Wilcox was for two years from April 18, 2007. Thereafter, Mr. Wilcox's employment agreement automatically renews for additional two-year terms unless at least 30 days prior to the end of a two-year term, USPI or Mr. Wilcox gives notice that it or he does not wish to extend the agreement. Mr. Wilcox is paid a base salary of $650,000 per year, subject to increase from time to time with the possibility of a bonus, determined by the compensation committee in its sole discretion.

The initial term of our employment agreement with Brett P. Brodnax was for one year from April 18, 2007. Thereafter, Mr. Brodnax's agreement automatically renews for additional one-year terms unless at least 30 days prior to the end of a one-year term, USPI or Mr. Brodnax gives notice that it or he does not wish to extend the agreement. Mr. Brodnax is paid a base salary of $600,000 per year, subject to increase from time to time with the possibility of a bonus, determined by the compensation committee in its sole discretion.

The initial term of our employment agreement with Jason B. Cagle is for one year from April 18, 2007. Thereafter, Mr. Cagle's employment agreement automatically renews for additional one-year terms unless at 30 days prior to the end of a one-year term, USPI or Mr. Cagle gives notice that it or he does not wish to extend the agreement. Mr. Cagle is paid a base salary of $400,000 per year, subject to increase from time to time with the possibility of a bonus determined by the compensation committee in its sole discretion.

The initial term of our employment agreement with Philip A. Spencer was for three years from July 29, 2009. Thereafter, Mr. Spencer's employment agreement automatically renews for additional one-year terms unless at 30 days prior to the end of a one-year term, USPI or Mr. Spencer gives notice that it or he does not wish to extend the agreement. Mr. Spencer is paid a base salary of $390,000 per year, subject to increase from time to time with the possibility of a bonus determined by the compensation committee in its sole discretion.

The initial term of our employment agreement with Sandra R.A. Karmann was for one year from January 7, 2013. Thereafter, Ms. Karmann's employment agreement automatically renews for additional one-year terms unless at 30 days prior to the end of a one-year term, USPI or Ms. Karmann gives notice that it or she does not wish to extend the agreement. Ms. Karmann is paid a base salary of $390,000 per year, subject to increase from time to time with the possibility of a bonus determined by the compensation committee in its sole discretion; provided however, Ms. Karmann's bonus for 2014 is a minimum of $100,000.

Each of the employment agreements with our named executive officers also provides that if the executive is terminated for cause, or if he terminates his employment agreement without certain enumerated good reasons, we shall pay to him any accrued or unpaid base salary through the date of his termination. In addition, if we terminate the employment without cause or upon failure to renew his employment agreement, or if he terminates his employment for certain enumerated good reasons, we will (i) continue to pay him his base salary at the rate in effect on the date of his termination for 12 months; (ii) continue his health insurance benefits for 12 months following his date of termination (24 months for Mr. Wilcox) or the economic equivalent thereof if such continuation is not permissible under the terms of our health insurance plan; and (iii) pay him a good faith estimate of the bonus he would have received had he remained employed through the end of the fiscal year in which his termination occurred. Our obligations set forth in items (i) to (iii) above are conditioned on the executive signing a release of claims and the continued performance of his continuing obligations under his employment agreement.

In connection with the consummation of the merger and the adoption of our Parent's equity plan, certain of our executive officers, including our named executive officers who were employed by USPI at the time of the merger, were awarded restricted shares of our Parent's common stock under the equity plan pursuant to an agreement between each such named executive officer and our Parent. Pursuant to these restricted stock award agreements with our named executive officers, upon termination of such named executive officer's employment for any reason (including, without limitation, as a result of death, disability, incapacity, retirement, resignation, or dismissal with or without cause), any vested shares as of the date of such termination shall remain vested shares and no additional shares will become vested after the date of such termination unless USPI consummates a change of control within 180 days after such named executive officer's termination, in which case, such unvested shares shall become fully vested if such awards would have become fully vested had such named executive officer not been terminated on the date of such change of control as described below. Additionally, pursuant to such restricted stock award agreements with our named executive officers, all unvested restricted shares vest in full upon a change of control if, as a result of such change of control, Welsh Carson shall have disposed of all of its shares of our Parent acquired in connection with the merger and received its cost basis in such shares plus a return of at least 100%. In the event such restricted shares do not vest on such change of control, then such restricted shares shall be forfeited upon the closing of such change of control.

Potential Payments Upon Termination or Change of Control

The following table sets forth for each named executive officer potential post-employment payments and payments on a change in control and assumes that the triggering event took place on December 31, 2014.

Name	Cash Severance Payment	Accrued Bonus(1)(2)	Benefits(3)	Accelerated Vesting of Restricted Stock Awards upon Change of Control(4)	Accelerated Vesting of Stock Option Awards upon Change of Control(5)
William H. Wilcox	$1,300,000(6)	$303,608	$16,416(6)	$ 6,173,802	$ —
Brett P. Brodnax	600,000(7)	184,492	12,696(7)	2,635,584	140,000
Jason B. Cagle	400,000(7)	145,307	14,772(7)	188,125	396,000
Philip A. Spencer	390,000(7)	91,103	5,881(7)	537,500	129,000
Sandra R.A. Karrmann	390,000(7)	100,000	14,772(7)	—	171,000

(1) Amounts are based on the bonus amount paid with respect to 2014.

(2) Amounts will be paid at such time as annual bonuses are payable to other executive and officers of USPI in accordance with USPI's normal payroll practices.

(3) Amounts consist of the cost to continue to pay such named executive officer's health insurance benefits for the designated term or the economic equivalent thereof if such continuation is not permissible under the terms of the USPI's health insurance plan.

(4) Pursuant to the restricted stock award agreements with our named executive officers, all unvested restricted shares of our Parent's common stock will vest in full upon a change of control if, as a result of such change of control, Welsh Carson shall have disposed of all of its shares of our Parent acquired in connection with the merger and received its cost basis in such shares plus a return of at least 100%. A change of control is not defined to include an initial public offering of our stock. In the event such restricted shares do not vest on such change of control, then such restricted shares shall be forfeited upon the closing of such change of control transaction. The results in this column are the result of multiplying the total possible number of restricted shares of our Parent's common stock that vest upon a change of control by $2.15 per share. Because there is no active trading market for our common stock, we rely on members of the compensation committee and Welsh Carson to determine in good faith the fair value of our common stock. As of December 31, 2014, this value was determined to be $2.15 per share of common stock. Neither USPI, USPI Holdings, Inc. nor USPI Group Holdings, Inc. has any class of equity securities registered under Section 12 of the Exchange Act.

(5) Pursuant to the 2007 Equity Incentive Plan, upon a change of control, unvested options of our named executive officers shall vest. The results in this column are the result of multiplying the number of unvested options by the difference of the fair value of our common stock on December 31, 2014 of $2.15 per share and the exercise price applicable to the named executive officer's option award.

(6) Amounts to be paid over twenty-four months.

(7) Amounts to be paid over twelve months.

Director Compensation

The chairman and members of our board of directors who are also officers or employees of USPI, affiliates of Welsh Carson and Mr. Allison do not receive compensation for their services as directors. At Mr. Allison's direction, his compensation for his service as a director are paid to his employer, Baylor Scott & White Health. At Mr. Paz's direction, $26,250 of his compensation for his service as a director for 2014 were paid to his employer, Pennsylvania State University. The other directors ("non-employee directors") receive cash compensation in the amount of $50,000 per year and are eligible to participate in our group insurance benefits. If a non-employee director elects to participate, the director will pay the full cost of such benefits. Non-employee directors also receive the following for all meetings attended: $2,500 per board meeting, $1,250 per telephonic meeting, $3,000 per audit committee meeting and $1,000 per other committee meeting. In addition, the audit committee chairman is paid a retainer of $20,000 per year.

The following table sets forth the compensation paid to our non-employee directors in 2014.

2014 Non-Employee Director Compensstion Table

Name	Fees Earned or Paid in Cash	Stock Awards(1)	All Other Compensation(2)	Total
Joel T. Allison	$ —	$ —	$ —	$ —
John C. Garrett, M.D.	67,000	78,750	19,700	165,450
James Ken Newman	65,750	78,750	19,700	164,200
Harold L. Paz, M.D., M.S.	25,000	250,000	—	275,000
Raymond A. Ranelli	84,500	78,750	19,700	182,950

(1) We account for the cost of stock-based compensation awarded under the 2007 Equity Incentive Plan adopted by our Parent under which the cost of equity awards to employees is measured by the aggregate grant date fair value of the awards on their grant date calculated in accordance with the FASB's *Accounting Standards Codification* Topic 718. No forfeitures occurred during 2014. On May 1, 2014 a grant of 45,000 restricted shares was made to each of Parent's non-employee directors with the exception of Dr. Paz. On September 26, 2014, Dr. Paz received a grant of 125,000 restricted shares. The restricted shares were valued at $1.75 and $2.00 per share, respectively, equal to the fair value per share of common stock as determined by the compensation committee. The shares vest 25% per year over four years.

(2) Non-employee directors were issued a cash stipend of $19,700 in connection with the stock awards issued in May 2014.

Compensation Risk Assessment

At the request of the Compensation Committee, management conducted an assessment of the Company's compensation plans to determine whether such plans encourage excessive or inappropriate risk taking by our employees. This assessment included a review of the risk characteristics of our business and the design of our compensation plans. Although a significant portion of our executive compensation program is performance-based, the Compensation Committee has focused on aligning the Company's compensation plans with the long-term interests of the Company and its stockholders and avoiding rewards or incentive structures that could encourage unnecessary risks to the Company.

Management reported its findings from this assessment to the Compensation Committee. The Compensation Committee agreed that the Company's compensation plans do not encourage excessive or inappropriate risk taking and are not reasonably likely to have a material, adverse effect on the Company.

Compensation Committee Interlocks and Insider Participation

The compensation committee of the board of directors consists of Messrs. Queally (Chairman) and Mackesy. None of such persons are officers or employees or former officers or employees of the Company. None of the executive officers of the Company served as a member of the compensation committee of any other company during 2014.

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

USPI does not issue any of its equity securities in conjunction with an equity compensation plan. See Item 11, "Executive Compensation — Restricted Stock and Option Plan," for a discussion of Parent's equity compensation plan.

All of the issued and outstanding stock of USPI is owned by Holdings, which in turn is wholly-owned by Parent. The following table sets forth information as of February 23, 2014, with respect to the beneficial ownership of the capital stock of our Parent by (i) our chief executive officer and each of the other named executive officers, (ii) each of our directors, (iii) all of our directors and executive officers as a group and (iv) each holder of five percent (5%) or more of any class of our Parent's outstanding capital stock.

Except as described in the agreements mentioned above or as otherwise indicated in a footnote, each of the beneficial owners listed has, to our knowledge, sole voting, dispositive and investment power with respect to the indicated shares of common stock beneficially owned by them.

Name of Beneficial Owner(1)	Common Shares Beneficially Owned	Percent of Outstanding Common Shares	Participating Preferred Shares Beneficially Owned	Percent of Outstanding Participating Preferred Shares
Welsh, Carson, Anderson & Stowe(2)	136,623,356	82.6%	17,326,775	96.3%
California State Teacher's Retirement System(3)	22,183,099	13.4%	2,816,901	15.7%
CPP Investment Board (USRE II) Inc.(4)	26,619,718	16.1%	3,380,282	18.8%
Silvertech Investment PTE Ltd(5)	8,873,239	5.4%	1,126,761	6.3%
William H. Wilcox(6)	6,188,790	3.7%	236,619	1.3%
Brett P. Brodnax(7)	3,138,811	1.9%	27,042	*
Jason B. Cagle(8)	674,618	*	7,888	*
Philip A. Spencer(9)	613,310	*	1,690	*
Sandra R.A. Karrmann(10)	150,000	*	—	*
Joel T. Allison	—	—	—	—
Anthony F. Ecock(11)	—	—	—	—
John C. Garrett, M.D.(12)	258,095	*	16,901	*
D. Scott Mackesy(11)(13)	125,000	*	—	—
James K. Newman(14)	302,463	*	22,535	*
Paul B. Queally(11)(15)	255,457	*	22,281	*
Raymond A. Ranelli(13)	182,363	*	7,885	*
Harold L. Paz, M.S., M.D.(12)	125,000	*	—	*
All directors and executive officers as a group(17)	12,013,908	7.3%	342,841	1.9%

* Less than one percent

(1) Unless otherwise indicated, the principal executive offices of esch of the beneficial owners identified are located at 15305 Dallas Parkway, Suite 1600, Addison, Texas 75001.

(2) Represents (A) 54,671,610 common shares and 6,942,423 participating preferred shares held by Welsh Carson over which Welsh Carson has sole voting and investment power, (B) 200,200 common shares and 3,200 participating preferred shares held by WCAS Management Corporation, an affiliate of Welsh Carson, over which WCAS Management Corporation has sole voting and investment power, (C) an aggregate 1,462,785 common shares and 185,752 participating preferred over which individuals who are general partners of WCAS X Associates LLC, the sole general partner of Welsh Carson, and/or otherwise employed by an affiliate of Welsh, Carson, Anderson & Stowe have voting and investment power, and (D) an aggregate 80,288,761 common shares and 10,195,400 participating preferred shares held by other co-investors, over which Welsh Carson has sole voting power. WCAS X Associates LLC, the sole general partner of Welsh Carson and the individuals who serve as general partners of WCAS X Associates LLC, including D. Scott Mackesy, Paul B. Queally and Anthony F. Ecock, may be deemed to beneficially own the shares beneficially owned by Welsh Carson. Such persons disclaim beneficial ownership of such shares. The principal executive offices of Welsh, Carson, Anderson & Stowe are located at 320 Park Avenue, Suite 2500, New York, New York 10022.

(3) Such beneficial owner has granted to Welsh Carson sole voting power over its shares. The principal executive offices of such beneficial owner is 7667 Folsom Blvd., Suite 250, Sacramento, California 95826.

(4) Such beneficial owner has granted to Welsh Carson sole voting power over its shares. The principal executive offices of such beneficial owner is One Queen Street East, Suite 2600, Toronto, Ontario, M5C 2W5, Canada.

(5) Such beneficial owner has granted to Welsh Carson sole voting power over its shares. The principal executive offices of such beneficial owner is 255 Shoreline Drive, Suite 600, Redwood City, California 94065.

(6) Represents (A) 1,242,254 common shares and 157,746 participating preferred shares, (B) 4,196,536 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the LBO, and (C) 275,000 common shares, 39,436 participating preferred shares and 100,000 common shares subject to restrictions on transfer owned by each of the Michelle Ann Steen Trust and the Marcus Anthony Steen Trust for which, in each case, Mr. Wilcox acts as trustee and has voting and investment power over such shares. Not included are 1,000,000 common shares owned by the 2012 WHW Descendants Trust over which Mr. Wilcox's spouse is trustee.

(7) Represents (A) 212,958 common shares and 27,042 participating preferred shares, (B) 2,175,853 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the LBO and (C) 750,000 options that are exercisable.

(8) Represents (A) 62,118 common shares and 7,888 participating preferred shares, (B) 175,000 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the LBO and (C) 437,500 options that are exercisable.

(9) Represents (A) 13,310 common shares and 1,690 participating preferred shares, (B) 500,000 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of initial employment with USPI and (C) 100,000 options that are exercisable.

(10) Represents 150,000 options that are exercisable.

(11) Does not include (A) 54,671,610 common shares or 6,942,423 participating preferred shares owned by Welsh Carson, or (B) 25,200 common shares or 3,200 participating preferred shares owned by WCAS Management Corporation. Messrs Qucally, Mackesy and Ecock, as general partners of WCAS X Associates LLC, the sole general partner of Welsh Carson, and officers of WCAS Management Corporation, may be deemed to beneficially own the shares beneficially owned by Welsh Carson and WCAS Management Corporation. Each of Messrs Queally, Mackesy and Ecock disclaims beneficial ownership of such shares. The principal executive offices of Messrs Qucally, Mackesy and Ecock are located at 320 Park Avenue, Suite 2500, New York, New York 10022.

(12) Represents (A) 133,095 common shares and 16,901 participating preferred shares and (B) 125,000 common shares which are subject to restrictions set forth in a restricted stock award agreement.

(13) Represents 125,000 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement.

(14) Represents (A) 177,463 common shares and 22,535 participating preferred shares and (B) 125,000 common shares which are subject to restrictions set forth in a restricted stock award agreement.

(15) Represents (A) 172,367 common shares and 21,888 participating preferred shares, (B) an aggregate 3,090 common shares and 393 preferred shares owned by certain trusts established for the benefit of Mr. Qucally's children for which, in each case, Mr. Qucally acts as a trustee and has voting and investment power over such shares and (C) 80,000 common shares which are subject to restrictions on transfer set forth in a restricted stock awards agreement.

(16) Represents (A) 57,363 common shares and 7,885 participating preferred shares and 80,000 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement owned by the Lisa C. Ranelli Trust for which Mr. Ranelli acts as trustee and has voting and investment power over such shares, and (B) 45,000 common shares which are subject to restrictions on transfer set forth in a restrieted stock award agreement.

(17) Does not include (A) 54,671,610 common shares or 6,942,423 participating preferred shares owned by Welsh Carson, or (B) 25,200 common shares or 3,200 participating preferred shares owned by WCAS Management Corporation. Includes an aggregate 9,897,592 common shares which are subject to restrictions on transfer set forth in restricted stock award agreements entered into at the time of the consummation of the LBO.

Item 13. *Certain Relationships and Related Transactions, and Director Independence*

This section describes certain relationships and transactions involving us and certain of our directors, executive officers, and other related parties. We believe that all the transactions described in herein are upon fair and reasonable terms no less favorable than could be obtained in comparable arm's length transactions with unaffiliated third parties under the same or similar circumstances.

Arrangements with Our Investors

Welsh Carson, its co-investors and the rollover stockholders entered into agreements described below with our Parent. Welsh Carson's co-investors includes individuals and entities invited by Welsh Carson to participate in our Parent's financings such as affiliated investment funds, individuals employed by affiliates of Welsh Carson and limited partners of Welsh Carson.

Stockholders Agreement

The stockholders agreement contains certain restrictions on the transfer of equity securities of our Parent and provides certain stockholders with certain preemptive and information rights.

Management Agreement

In connection with the merger, USPI entered into a management agreement with WCAS Management Corporation, an affiliate of Welsh Carson, pursuant to which WCAS Management Corporation will provide management and financial advisory services to us. WCAS Management Corporation receives an annual management fee of $2.0 million, of which $1.0 million is payable in cash on an annual basis and the remainder accrues annually over time and will be paid upon a change in control, and annual reimbursement for out-of-pocket expenses incurred in connection with the provision of such services.

Revolving Line of Credit

The Company has a revolving line of credit with European Surgical Partners Limited (ESP) of up to $3.0 million, a company owned in part by Welsh Carson, its co-investors and the rollover stockholders. The balance owed to the Company by ESP was $2.5 million at December 31, 2014, and the borrowing bears interest at 6.50% per annum and matures upon the earlier of the refinance or discharge of ESP under its current third-party credit facility, at which time all principal and interest is due. The Company believes that the terms of the revolving line of credit are approximately the same as if they had been negotiated on an arms' length basis.

Other Arrangements with Directors and Executive Officers

Restricted Stock and Option Plan

In connection with the merger, our Parent adopted a new restricted stock and option plan. Members of our management, including some of those who participated in the merger as rollover stockholders, received awards under this plan. See "Compensation Discussion and Analysis — Restricted Stock and Option Plan."

Employment Agreements

Each of the named executive officers of USPI has employment agreements with us. See "Compensation Discussion and Analysis — Employment Arrangements and Agreements."

Other Arrangements

We have entered into agreements with certain majority and minority owned surgery centers to provide management services. As compensation for these services, the surgery centers are charged management fees which are either fixed in amount or represent a fixed percentage of each center's net revenue less bad debt. The percentages range from 3% to 8%. Amounts recognized under these agreements, after elimination of amounts from consolidated surgery centers, totaled approximately $80.6 million, $71.1 million, and $67.6 million in 2014, 2013, and 2012, respectively, and are included in management and contract service revenues in our consolidated statements of income.

We regularly engage in purchases and sales of ownership interests in our facilities. We operate 33 surgical facilities in partnership with a Baylor Scott & White Health affiliated entity (Baylor Scott & White) and local physicians in the Dallas/Fort Worth area. Baylor Scott & White Health's Chief Executive Officer is a member of our board of directors. The following table summarizes transactions with Baylor Scott & White during 2013. We had no such transactions in 2014 and 2012. We believe that the sale price was approximately the same as if it had been negotiated on an arms' length basis, and the price equaled the value assigned by an external appraiser who valued the business immediately prior to the sale.

Date	Facility Location	Proceeds	Gain
January 2013	Dallas, Texas(1)	$ 9.0 million	$ — million

(1) We contributed two surgery centers to a joint venture with Baylor Scott & White. We continue to account for these facilities under the equity method.

Additionally, we derived approximately 3% of our revenues and approximately 44% of our equity in earnings of unconsolidated affiliates in 2014 from our joint venture with Baylor Scott & White.

We do not have a written policy on related party transactions, however, the audit and compliance committee will review and approve all related party transactions required to be reported pursuant to item 404(a) of Regulation S-X.

Neither the Company, USPI Holdings, Inc. nor USPI Group Holdings, Inc. are listed on a national securities exchange or in an automated inter-dealer quotation system of a national securities association, and we are not subject to either the listing standards of the New York Stock Exchange or the NASDAQ Rules. For the purposes of the following determinations of director independence, we have chosen to use the NASDAQ Rules. Using such Rules, we have determined that each of the directors on our board of directors are independent for general board service, except Messrs. Wilcox, Mackesy, Queally, Ecock and Allison.

Our board of directors has a separately designated, standing audit and compliance committee comprised of the following members of the board: Messrs. Ranelli (Chairman), Garrett and Newman. Under the NASDAQ Rules, Messrs. Ranelli, Garrett and Newman would be considered independent for the purposes of audit and compliance committee service.

Our board of directors also has a separately designated, standing compensation committee comprised of the following members of the board: Messrs. Queally (Chairman) and Mackesy. Under the NASDAQ Rules, Messrs. Queally and Mackesy would not be considered independent for the purposes of compensation committee service.

ITEM 14. ***Principal Accounting Fees and Services***

The following table shows the aggregate fees billed by KPMG LLP, our independent registered public accounting firm, during the years ended December 31, 2014 and 2013:

Description of Fees	2014	2013
Audit Fees(1)	$ 1,491,000	$ 1,578,234
Audit Related Fees(2)	—	—
Tax Fees(3)	—	—
All Other Fees(4)	—	222,500
	$ 1,491,000	$ 1,800,234

(1) *Audit Fees.* Includes fees billed for professional services rendered for the audit of our annual financial statements included in our Form 10-K, reviews of our quarterly financial statements included in Forms 10-Q, audits of subsidiaries, reviews of our other filings with the SEC, and other research work necessary to comply with generally accepted accounting standards for the years ended December 31, 2014 and 2013.

(2) *Audit Related Fees.* Includes fees billed for assurance and related services that are reasonably related to the performance of the audit or review of our financial statements and are not reported under "Audit Fees." These services include other accounting and reporting consultations.

(3) *Tax Fees.* Includes fees billed for tax compliance, tax advice, and tax planning.

(4) *All Other Fees.* Includes fees billed for assistance with preparation of Medicare cost reports.

The charter of our audit and compliance committee provides that the committee must approve in advance all audit and non-audit services provided by KPMG LLP. The audit and compliance committee approved all of these services.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules***

(a) (1) Financial Statements

The following consolidated financial statements are filed as part of this Form 10-K:

Attachment 15

Repurt of Independent Registered Public Accounting Firm

The Board of Directors and Stockholder
United Surgical Partners International, Inc.:

We have audited the accompanying consolidated balance sheets of United Surgical Partners International, Inc. (the Company) and subsidiaries as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, changes in equity, and cash flows for each of the years in the three-year period ended December 31, 2014. In connection with our audits of the consolidated financial statements, we also have audited the financial statement schedule. These consolidated financial statements and the financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these cunsolidated financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of United Surgical Partners International, Inc. and subsidiaries as of December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2014, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), United Surgical Partners International, Inc.'s internal control over financial reporting as uf December 31, 2014, based on criteria established in *Internal Control — Integrated Framework—1992* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 25, 2015 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

Dallas, Texas
Fcbruary 25, 2015

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholder
United Surgical Partners International, Inc.:

We have audited United Surgical Partners International, Inc.'s (the Company) internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control — Integrated Framework—1992* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, United Surgical Partners International, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control — Integrated Framework—1992* issued by the COSO.

The Company acquired several subsidiaries and equity method investments during 2014, and management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2014, the following subsidiary's and equity method investment's internal control over financial reporting associated with total assets of $96.5 million and total revenues of $2.3 million included in the consolidated financial statements of United Surgical Partners International, Inc. and subsidiaries as of and for the year ended December 31, 2014. Our audit of internal control over financial reporting of the Company also excluded an evaluation of the internal control over financial reporting of the following subsidiaries and equity method investments:

- USP Hazelwood, Inc.
- USP Morris, Inc.
- USP Siouxland, Inc.
- USP Sacramento, Inc. (Investment in Hacienda Outpatient Surgery Center, LLC)
- USP San Antonio, Inc. (Investment Alamo Heights Surgical Hospital Group, LP)

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of United Surgical Partners International, Inc. and subsidiaries as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, changes in equity, and cash flows for each of the years in the three-year period ended December 31, 2014, and our report dated February 25, 2015 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Dallas, Texas
February 25, 2015

UNITED SURGICAL PARTNERS INTERNATIONAL, INC. AND SUBSIDIARIES

Consolidated Balance Sheets
December 31, 2014 and 2013

	2014	2013
	(In thousands, except share amounts)	
ASSETS		
Cash and cash equivalents (Note 1)	$ 36,554	$ 78,741
Available for sale securities (Note 1)	10,831	10,802
Accounts receivable, net of allowance for doubtful accounts of $11,974 and $10,236 respectively	57,616	51,608
Other receivables (Note 6)	23,568	24,191
Inventories of supplies	8,681	9,049
Deferred tax asset, net (Note 12)	29,518	22,333
Prepaids and other current assets	16,210	16,076
Total current assets	182,978	212,800
Property and equipment, net (Note 7)	128,887	132,474
Investments in unconsolidated affiliates (Note 3)	605,100	521,833
Goodwill (Note 8)	1,265,461	1,229,282
Intangible assets, net (Note 8)	368,190	356,119
Other assets (Note 11)	33,241	28,176
Total assets	$2,583,857	$2,480,684
LIABILITIES AND EQUITY		
Accounts payable	$ 23,272	$ 17,407
Accrued salaries and benefits	32,571	28,932
Due to affiliates	159,608	184,961
Accrued interest	10,045	10,034
Current portion of long-term debt (Note 9)	18,668	18,916
Other current liabilities	63,359	54,949
Total current liabilities	307,523	315,199
Long-term debt, less current portion (Note 9)	1,457,203	1,454,692
Other long-term liabilities	37,868	36,030
Deferred tax liability, net (Note 12)	205,426	181,543
Total liabilities	2,008,020	1,987,464
Noncontrolling interests — redeemable (Note 4)	195,059	166,578
Commitments and contingencies (Notes 4 and 14)		
Equity (Note 13)		
United Surgical Partners International, Inc. (USPI) stockholder's equity:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding	—	—
Additional paid-in capital	220,135	228,794
Accumulated other comprehensive income (loss), net of tax	(4)	10
Retained earnings	111,713	50,818
Total USPI stockholder's equity	331,844	279,622
Noncontrolling interests — nonredeemable (Note 4)	48,934	47,020
Total equity	380,778	326,642
Total liabilities and equity	$2,583,857	$2,480,684

See accompanying notes to consolidated financial statements

UNITED SURGICAL PARTNERS INTERNATIONAL, INC. AND SUBSIDIARIES

Consolidated Statements of Income

	Year Ended December 31, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012
		(In thousands)	
Revenues:			
Net patient service revenues	$ 533,811	$ 517,738	$ 451,598
Management and contract service revenues	96,392	87,559	79,438
Other revenues	10,621	10,934	9,199
Total revenues	640,824	616,231	540,235
Equity in earnings of unconsolidated affiliates	116,607	95,520	96,393
Operating expenses:			
Salaries, benefits, and other employee costs	175,463	163,667	138,020
Medical services and supplies	109,636	101,149	83,546
Other operating expenses	110,642	99,425	87,173
General and administrative expenses	48,365	41,458	41,434
Provision for doubtful accounts	10,658	10,006	9,678
Net losses on deconsolidations, disposals and impairments (Notes 2, 3 and 8)	6,887	5,017	7,588
Depreciation and amortization	26,004	27,238	23,955
Total operating expenses	487,655	447,960	391,394
Operating income	269,776	263,791	245,234
Interest income	1,287	1,359	676
Interest expense	(95,028)	(101,163)	(85,934)
Loss on early retirement of debt	—	(5,536)	(37,450)
Other, net	(68)	(2)	(613)
Total other expense, net	(93,809)	(105,342)	(123,321)
Income from continuing operations before income taxes	175,967	158,449	121,913
Income tax expense (Note 12)	(37,507)	(31,389)	(21,502)
Income from continuing operations	138,460	127,060	100,411
Discontinued operations, net of tax (Note 2):			
Income from discontinued operations	—	—	3,073
Loss on disposal of discontinued operations	(332)	—	—
Total earnings (loss) from discontinued operations	(332)	—	3,073
Net income	138,128	127,060	103,484
Less: Net income attributable to noncontrolling interests	(77,081)	(78,782)	(72,693)
Net income attributable to USPI's common stockholder	$ 61,047	$ 48,278	$ 30,791
Amounts attributable to USPI's common stockholder:			
Income from continuing operations, net of tax	$ 61,379	$ 48,278	$ 27,777
Earnings (loss) from discontinued operations, net of tax	(332)	—	3,014
Net income attributable to USPI's common stockholder	$ 61,047	$ 48,278	$ 30,791

See accompanying notes to consolidated financial statements

UNITED SURGICAL PARTNERS INTERNATIONAL, INC. AND SUBSIDIARIES

Consolidated Statements of Comprehensive Income

	Year Ended December 31, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012
		(In thousands)	
Net income	$ 138,128	$ 127,060	$ 103,484
Other comprehensive income (loss):			
Foreign currency translation adjustments	—	—	4,938
Unrealized loss on foreign currency contract, net of tax	—	—	(560)
Unrealized gain (loss) on available for sale securities, net of tax	(14)	(54)	22
Unrealized gain on interest rate swaps, net of tax	—	—	15
Reclassification due to spin-off of U.K. subsidiary:			
Foreign currency translation adjustments	—	--	58,682
Total other comprehensive income (loss)	(14)	(54)	63,097
Comprehensive income	138,114	127,006	166,581
Less: Comprehensive income attributable to noncontrolling interests	(77,081)	(78,782)	(72,693)
Comprehensive income attributable to USPI's common stockholder	$ 61,033	$ 48,224	$ 93,888

See accompanying notes to consolidated financial statements

UNITED SURGICAL PARTNERS INTERNATIONAL, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Equity

	USPI Common Stockholder						
	Outstanding Shares	Par Value	Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Noncontrolling Interests — Nonredeemable	Total
	(In thousands, except share amounts)						
Balance, December 31, 2011	100	$ —	$ 778,030	$ (63,033)	$ 17,691	$ 35,183	$ 767,871
Distributions to noncontrolling interests	—	—	—	—	—	(10,524)	(10,524)
Purchases of noncontrolling interests	—	—	1,568	—	—	(322)	1,246
Sales of noncontrolling interests	—	—	(18,664)	—	—	5,674	(12,990)
Contribution related to equity award grants by USPI Group Holdings, Inc. and other	—	—	1,981	—	—	—	1,981
Spin-off of U.K. subsidiary (Note 2)	—	—	(193,320)	—	—	(523)	(193,843)
Dividend to Parent's equity holders (Note 13)	—	—	(338,539)	—	(45,887)	—	(384,426)
Net income	—	—	—	—	30,791	8,784	39,575
Other comprehensive income	—	—	—	63,097	—	—	63,097
Balance, December 31, 2012	100	—	231,056	64	2,595	38,272	271,987
Distributions to noncontrolling interests	—	—	—	—	—	(9,256)	(9,256)
Purchases of noncontrolling interests	—	—	6,431	—	—	(1,395)	5,036
Sales of noncontrolling interests	—	—	(10,356)	—	—	6,094	(4,262)
Acquisition of new business	—	—	—	—	—	2,179	2,179
Contribution related to equity award grants by USPI Group Holdings, Inc. and other	—	—	1,663	—	—	—	1,663
Dividend to Parent's equity holders	—	—	—	—	(55)	—	(55)
Net income	—	—	—	—	48,278	11,126	59,404
Other comprehensive loss	—	—	—	(54)	—	—	(54)
Balance, December 31, 2013	100	—	228,794	10	50,818	47,020	326,642
Distributions to noncontrolling interests	—	—	—	—	—	(11,094)	(11,094)
Purchases of noncontrolling interests	—	—	2,192	—	—	(1,138)	1,054
Sales of noncontrolling interests	—	—	(14,195)	—	—	1,863	(12,332)
Contribution related to equity award grants by USPI Group Holdings, Inc. and other	—	—	3,344	—	—	—	3,344
Dividend to Parent's equity holders	—	—	—	—	(152)	—	(152)
Net income	—	—	—	—	61,047	12,283	73,330
Other comprehensive loss	—	—	—	(14)	—	—	(14)
Balance, December 31, 2014	100	$ —	$ 220,135	$ (4)	$ 111,713	$ 48,934	$ 380,778

See accompanying notes to consolidated financial statements

UNITED SURGICAL PARTNERS INTERNATIONAL, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

	Year Ended December 31, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012
		(in thousands)	
Cash flows from operating activities:			
Net income	$ 138,128	$ 127,060	$ 103,484
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss (earnings) from discontinued operations	332	—	(3,073)
Loss on early retirement of debt	—	5,536	37,450
Provision for doubtful accounts	10,658	10,006	9,678
Depreciation and amortization	26,004	27,238	23,955
Amortization of debt issue costs and discount	4,497	4,338	4,027
Deferred income taxes	12,943	5,936	3,672
Net losses on deconsolidations, disposals and impairments	6,887	5,017	7,588
Equity in earnings of unconsolidated affiliates, net of distributions received	2,005	(19,571)	(9,502)
Equity-based compensation	3,358	1,841	1,677
Increases (decreases) in cash from changes in operating assets and liabilities, net of effects from purchases of new businesses:			
Accounts receivable	(15,275)	(9,050)	(6,222)
Other receivables	6,093	(5,350)	(6,501)
Inventories of supplies, prepaids and other assets	(1,789)	(2,629)	(2,289)
Accounts payable and other current liabilities	18,492	7,698	14,115
Other long-term liabilities	(775)	1,822	2,254
Net cash provided by operating activities	211,558	159,892	180,313
Cash flows from investing activities:			
Purchases of new businesses and equity interests, net of cash received	(152,755)	(53,084)	(143,653)
Proceeds from sales of businesses and equity interests, net	1,958	10,036	2,543
Purchases of property and equipment	(12,281)	(20,599)	(20,202)
Sales (purchases) of marketable securities, net	64	(295)	(5,938)
Returns of capital from unconsolidated affiliates	22,000	0	4,718
(Increase) decrease in deposits and notes receivable	(4,229)	(799)	1,625
Net cash used in investing activities	(145,243)	(64,741)	(160,907)
Cash flows from financing activities:			
Proceeds from long-term debt, net of debt issuance costs	109,655	145,829	987,548
Payments on long-term debt	(113,921)	(164,614)	(590,338)
Net equity contribution from USPI Group Holdings, Inc. and other	(15)	(182)	(545)
(Purchases) sales of noncontrolling interests, net	(2,541)	(1,620)	4,763
Payment of common stock dividend	(152)	(55)	(384,426)
(Decrease) increase in cash held on behalf of unconsolidated affiliates	(25,800)	28,996	17,798
Distributions to noncontrolling interests	(75,728)	(75,967)	(77,760)
Net cash used in financing activities	(108,502)	(67,613)	(42,960)
Cash flows of discontinued operations:			
Operating cash flows	—	—	(8,745)
Investing cash flows	—	—	(11,383)
Financing cash flows	—	—	53,142
Effect of exchange rate changes on cash	—	—	(79)
Net cash provided by discontinued operations	—	—	32,935
Net (decrease) increase in cash and cash equivalents	(42,187)	27,538	9,381
Cash and cash equivalents at beginning of period	78,741	51,203	41,822
Cash and cash equivalents at end of period	$ 36,554	$ 78,741	$ 51,203
Supplemental information:			
Interest paid — continuing operations	$ 90,519	$ 96,870	$ 78,572
Income taxes paid — continuing operations	14,635	24,874	8,114
Interest paid — discontinued operations	—	—	772
Income taxes paid — discontinued operations	—	—	15,835
Non-cash transactions:			
Spin-off of U.K. subsidiary	$ —	$ —	$ (193,843)
Assets acquired under capital lease obligations — continuing operations	7,075	1,753	10,515

See accompanying notes to consolidated financial statements

SCHEDULE II: VALUATION AND QUALIFYING ACCOUNTS

Allowance for Doubtful Accounts

	Balance at Beginning of Period	Additions Charged to: Costs and Expenses	Additions Charged to: Other Accounts	Deductions[1]	Other Items[2]	Balance at End of Period
			(In thousands)			
Year ended December 31, 2012	$ 8,576	$ 9,678	$ —	$ (9,376)	$1,026	$ 9,904
Year ended December 31, 2013	9,904	10,006	—	(10,492)	818	10,236
Year ended December 31, 2014	10,236	10,658	—	(9,443)	523	11,974

Valuation allawance for deferred tax assets

	Balance at Beginning of Period	Additions Charged to: Costs and Expenses	Additions Charged to: Other Accounts	Deductions	Other Items[2]	Balance at End of Period
			(In thousands)			
Year ended December 31, 2012	$ 820	$ —	$ —	$ —	$ (820)	$ —
Year ended December 31, 2013	—	—	—	—	3,256	3,256
Year ended December 31, 2014	3,256	—	—	—	—	3,256

(1) Accounts written off.

(2) Balances from entities that were acquired, deconsolidated or sold.

All other schedules are omitted because they are not applicable or not required or because the required information is included in the consolidated financial statements or notes thereto.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

Consolidated Financial Statements
Years Ended June 30, 2014 and 2013
(With Independent Auditors' Report Thereon)

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED JUNE 30, 2014 AND 2013

CONTENTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Managers
Texas Health Ventures Group, L.L.C.:

We have audited the accompanying consolidated financial statements of Texas Health Ventures Group, L.L.C. and subsidiaries (the "Company"), which comprise the consolidated balance sheets as of June 30, 2014 and 2013, and the related consolidated statements of income and changes in equity, and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the prepsration and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Texas Health Ventures Group, L.L.C. and subsidiaries at June 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

/s/ PricewaterhouseCoopers LLP

November 11, 2014
Dallas, Texas

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS —
JUNE 30, 2014 AND 2013

	2014	2013
	(In thousands)	
ASSETS		
CURRENT ASSETS:		
Cash	$ 7,562	$ 9,930
Funds due from United Surgical Partners, Inc.	61,370	49,323
Patient receivables, net of allowance for doubtful accounts of $11,676 and $13,099 at June 30, 2014 and 2013, respectively	54,558	58,243
Supplies	11,531	11,350
Prepaid and other current assets	4,770	7,099
Total current assets	139,791	135,945
PROPERTY AND EQUIPMENT, net (Note 2)	171,447	193,958
OTHER LONG-TERM ASSETS:		
Investments in unconsolidated affiliates (Note 3)	3,077	2,420
Goodwill and intangible assets, net (Note 5)	195,021	179,568
Other	158	175
Total assets	$509,494	$512,066
LIABILITIES AND EQUITY		
CURRENT LIABILITIES:		
Accounts payable	$ 30,964	$ 31,731
Accrued expenses and other	24,732	33,346
Current portion of long-term obligations (Note 6)	12,755	11,804
Total current liabilities	68,451	76,881
LONG-TERM OBLIGATIONS, NET OF CURRENT PORTION (Note 6)	137,704	145,969
OTHER LIABILITIES	12,975	13,478
Total liabilities	219,130	236,328
COMMITMENTS AND CONTINGENCIES (Notes 6, 7, 8 and 9)		
NONCONTROLLING INTERESTS — REDEEMABLE	60,627	53,143
EQUITY:		
Members' equity	208,996	203,450
Noncontrolling interests — nonredeemable	20,741	19,145
Total equity	229,737	222,595
Total liabilities and equity	$509,494	$512,066

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME
FOR THE YEARS ENDED JUNE 30, 2014 AND 2013
(In thousands)

	2014	2013
REVENUES:		
Net patient service revenue	$686,146	$691,586
Management and royalty fee income (Note 8)	600	600
Other income	2,666	2,779
Totel revenues	689,412	694,965
EQUITY IN EARNINGS OF UNCONSOLIDATED AFFILIATES (Note 4)	1,749	1,510
OPERATING EXPENSES:		
Salaries, benefits, and other employee costs	160,519	154,323
Medical services and supplies	168,090	176,229
Management and royalty fees (Note 8)	27,900	28,276
Professional fees	5,334	4,322
Other operating expenses	98,255	94,734
Provision for doubtful accounts	14,644	19,146
Depreciation and amortization	26,972	26,462
Total operating expenses	501,714	503,492
Operating income	189,447	192,983
NONOPERATING INCOME (EXPENSES):		
Interest expense	(14,948)	(15,524)
Interest income (Note 8)	260	244
Other income (expense), net	(514)	249
Income before income taxes	174,245	177,952
INCOME TAXES	(3,806)	(4,383)
Net income	170,439	173,569
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS — Redeemable	(86,731)	(86,059)
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS — Nonredcemable	(3,626)	(5,222)
Net income attributable to thc Company	$ 80,082	$ 82,288

See accompanying notes to consolidated finaneial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
FOR THE YEARS ENDED JUNE 30, 2014 AND 2013
(In thousands)

	Equity				Noncontrolling Interests — Nonredeemable
	Total	USP	BUMC	Total	
Balance at June 30, 2012	$221,514	$101,167	$101,573	$202,740	$ 18,774
Net income	87,510	41,062	41,226	82,288	5,222
Distributions to members	(85,718)	(40,250)	(40,411)	(80,661)	(5,057)
Purchase of noncontrolling interests	(1,079)	(534)	(536)	(1,070)	(9)
Sales of noncontrolling interests	368	76	77	153	215
Balance at June 30, 2013	222,595	101,521	101,929	203,450	19,145
Net income	83,708	39,961	40,121	80,082	3,626
Distributions to members	(82,751)	(39,372)	(39,529)	(78,901)	(3,850)
Contributions from members	7,292	3,640	3,652	7,292	—
Purchase of noncontrolling interests	(884)	(1,346)	(1,351)	(2,697)	1,813
Sales of noncontrolling interests	(223)	(115)	(115)	(230)	7
Balance at June 30, 2014	$229,737	$104,289	$104,707	$208,996	$ 20,741

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2014 AND 2013
(In thousands)

	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net income	$ 170,439	$ 173,569
Adjustments to reconcile net income to net cash provided by operating activities:		
Provision for doubtful accounts	14,644	19,146
Depreciation and amortization	26,972	26,462
Amortization of debt issue costs	15	9
Equity in earnings of unconsolidated affiliates, net of distributions received	(657)	83
Gain on sale of assets	70	(172)
Changes in operating assets and liabilities, net of effects from purchases of new businesses:		
Patient receivables	(10,538)	(15,741)
Supplies, prepaids, and other assets	2,288	(4,018)
Accounts payable and accrued expenses	1,983	14,343
Net cash provided by operating activities	205,216	213,681
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of new businesses and equity interests, net of cash received of $98 for 2014	(8,099)	—
Purchases of property and equipment	(9,826)	(26,875)
Sales of property and equipment	8,345	538
Change in deposits and notes receivables	(59)	182
Change in funds due from United Surgical Partners, Inc.	(11,906)	(4,321)
Net cash used in investing activities	(21,545)	(30,476)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from debt obligations	4,740	23,113
Payments on debt obligations	(27,400)	(23,122)
Distributions to noncontrolling interest owners	(92,056)	(91,537)
Purchases of noncontrolling interests	(1,855)	(1,739)
Sales of noncontrolling interests	2,141	671
Contributioas from members	7,292	—
Distributions to members	(78,901)	(80,661)
Net cash used in financing activities	(186,039)	(173,275)
(DECREASE) INCREASE IN CASH	(2,368)	9,930
CASH, beginning of period	9,930	—
CASH, end of period	$ 7,562	$ 9,930
SUPPLEMENTAL INFORMATION:		
Cash paid for interest	$ 14,971	$ 15,868
Cash paid for income taxes	4,560	4,438
Noncash transactions:		
Assets acquired under capital leases	4,526	1,923
Capital expenditures included in accounts payable	2,107	—
Note payable to physician partners for acquisition	750	—

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

Consolidoted Financial Statements
Years Ended June 30, 2013 and 2012
(With Independent Auditors' Report Thereon)

20

Attachment
15

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
YEARS ENDED JUNE 30, 2013 AND 2012

CONTENTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Managers
Texas Health Ventures Group, L.L.C.:

We have audited the accompanying consolidated financial statements of Texas Health Ventures Group, L.L.C. and subsidiaries (the "Company"), which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related consolidated statements of income and changes in equity, and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Texas Health Ventures Group, L.L.C. and subsidiaries at June 30, 2013 and 2012, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

/s/ PricewaterhouseCoopers LLP

November 8, 2013
Dallas, Texas

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS —
JUNE 30, 2013 AND 2012

	2013	2012
	(In thousands)	
ASSETS		
CURRENT ASSETS:		
Cash	$ 9,930	$ —
Funds due from United Surgical Partners, Inc.	49,323	46,854
Patient receivables, net of allowance for doubtful accounts of $13,099 and $13,313 at June 30, 2013 and 2012, respectively	58,243	61,648
Supplies	11,350	11,200
Prepaid and other current assets	7,099	3,231
Total current assets	135,945	122,933
PROPERTY AND EQUIPMENT, net (Note 2 and 11)	193,958	192,984
OTHER LONG-TERM ASSETS:		
Investments in unconsolidated affiliates (Note 4)	2,420	2,503
Goodwill and intangible assets, net (Note 6)	179,568	180,426
Other	175	280
Total assets	$512,066	$499,126
LIABILITIES AND EQUITY		
CURRENT LIABILITIES:		
Accounts payable	$ 31,731	$ 19,869
Accrued expenses and other	33,346	21,511
Current portion of long-term obligations (Note 7)	11,804	11,688
Total current liabilities	76,881	53,068
LONG-TERM OBLIGATIONS, NET OF CURRENT PORTION (Note 7)	145,969	156,815
OTHER LIABILITIES	13,478	13,885
Total liabilities	236,328	223,768
COMMITMENTS AND CONTINGENCIES (Notes 7, 8, 9 and 10)		
NONCONTROLLING INTERESTS — REDEEMABLE	53,143	53,844
EQUITY:		
Members' equity	203,450	202,740
Noncontrolling interests — nonredeemable	19,145	18,774
Total equity	222,595	221,514
Total liabilities and equity	$512,066	$499,126

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME
FOR THE YEARS ENDED JUNE 30, 2013 AND 2012
(In thousands)

	2013	2012
REVENUES:		
Net patient service revenue	$691,586	$666,136
Management and royalty fee income (Note 9)	600	547
Other income	2,779	872
Total revenues	694,965	667,555
EQUITY IN EARNINGS OF UNCONSOLIDATED AFFILIATES (Note 4)	1,510	1,390
OPERATING EXPENSES:		
Salaries, benefits, and other employee costs	154,323	142,634
Medical services and supplies	176,229	160,942
Management and royalty fees (Note 9)	28,276	27,333
Professional fees	4,322	3,624
Other operating expenses	94,734	90,616
Provision for doubtful accounts	19,146	21,119
Depreciation and amortization	26,462	27,291
Total operating expenses	503,492	473,559
Operating income	192,983	195,386
NONOPERATING INCOME (EXPENSES):		
Interest expense	(15,524)	(17,044)
Interest income (Note 9)	244	236
Other income (expense), net	249	(271)
Income before income taxes	177,952	178,307
INCOME TAXES	(4,383)	(4,228)
Net income	173,569	174,079
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS — Redeemable	(86,059)	(86,872)
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS — Nonredeemable	(5,222)	(5,209)
Net income attributable to the Company	$ 82,288	$ 81,998

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
FOR THE YEARS ENDED JUNE 30, 2013 AND 2012
(In thousands)

		Equity			Noncontrolling Interests —
	Total	USP	BUMC	Total	Nonredeemable
Balance at June 30, 2011	$212,011	$ 97,210	$ 97,600	$194,810	$ 17,201
Net income	87,207	40,917	41,081	81,998	5,209
Distributions to members	(80,418)	(37,834)	(37,986)	(75,820)	(4,598)
Contributions from members	2,425	1,210	1,215	2,425	—
Purchase of noncontrolling interests	193	(595)	(597)	(1,192)	1,385
Sales of noncontrolling interests	96	259	260	519	(423)
Balance at June 30, 2012	221,514	101,167	101,573	202,740	18,774
Net income	87,510	41,062	41,226	82,288	5,222
Distributions to members	(85,718)	(40,250)	(40,411)	(80,661)	(5,057)
Purchase of noncontrolling interests	(1,079)	(534)	(536)	(1,070)	(9)
Sales of noncontrolling interests	368	76	77	153	215
Balance at June 30, 2013	$222,595	$101,521	$101,929	$203,450	$ 19,145

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2013 AND 2012
(In thousands)

	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net income	$ 173,569	$ 174,079
Adjustments to reconcile net income to net cash provided by operating activities:		
Provision for doubtful accounts	19,146	21,119
Depreciation and amortization	26,462	27,291
Amortization of debt issue costs	9	19
Equity in earnings of unconsolidated affiliates, net of distributions received	83	(205)
Gain on sale of assets	(172)	—
Changes in operating assets and liabilities, net of effects from purchases of new businesses:		
Patient receivables	(15,741)	(24,513)
Supplies, prepaids, and other assets	(4,018)	(714)
Accounts payable and accrued expenses	14,343	1,612
Net cash provided by operating activities	213,681	198,688
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of new businesses and equity interests, net of cash received of $404 for 2012	—	(3,181)
Purchases of property and equipment	(26,875)	(4,642)
Sales of property and equipment	538	—
Change in deposits and notes receivables	182	(17)
Change in funds due from United Surgical Partners, Inc.	(4,321)	(324)
Net cash used in investing activities	(30,476)	(8,164)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from debt obligations	23,113	—
Payments on debt obligations	(23,122)	(27,942)
Distributions to noncontrolling interest owners	(91,537)	(87,206)
Purchases of noncontrolling interests	(1,739)	(2,044)
Sales of noncontrolling interests	671	1,403
Distributions to members	(80,661)	(75,820)
Net cash used in financing activities	(173,275)	(191,609)
(DECREASE) INCREASE IN CASH	9,930	(1,085)
CASH, beginning of period	—	1,085
CASH, end of period	$ 9,930	$ —
SUPPLEMENTAL INFORMATION:		
Cash paid for interest	$ 15,868	$ 17,455
Cash paid for income taxes	4,438	3,837
Noncash transactions:		
Noncash assets contributed by Members (Note 3)	—	2,425
Assets acquired under capital leases	1,923	10,724

See accompanying notes to consolidated financial statements.

(4) *Exhibits:*

Exhibit Number	Description
2.1	Agreement and Plan of Merger dated as of January 27, 2006, by and among United Surgical Partners International, Inc., Peak ASC Acquisition Corp. and Surgis, Inc. (previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the Commission on January 31, 2006 and incorporated herein by reference).(1)
2.2	Agreement and Plan of Merger, dated as of January 7, 2007, by and among the Company, UNCN Holdings, Inc. and UNCN Acquisition Corp. (previously filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed with the Commission on January 8, 2007 and incorporated herein by reference).(1)
3.1	Amended and Restated Certificate of Incorporation (previously filed as Exhibit 3.1(A) to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)
3.2	Amended and Restated Bylaws (previously filed as Exhibit 3.1(B) to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)
4.1	Indenture, dated as of April 3, 2012 by and among USPI Finance Corp. and U.S. Bank National Association, as trustee (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.2	Supplemental Indenture, dated as of April 3, 2012, by and among the Company, the Subsidiary Guarantors named therein and U.S. Bank National Association, as trustee (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.3	Form of 9.000% Senior Notes due 2020 (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.4	Form of Notation of Subsidiary Guarantees (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.5	Registration Rights Agreement, dated April 3, 2012, by and between USPI Finance Corp. and Barclays Capital Inc., as representative of the several initial purchasers named therein (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.6	Registration Rights Agreement Joinder, dated as of April 3, 2012, by and between the Company, the Subsidiary Guarantors and Barclays Capital Inc., as representative of the several purchasers named therein (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.1	Credit Agreement, dated as of April 19, 2007, among USPI Holdings, Inc., the Company, as Borrower, the Lenders party thereto, Citibank, N.A., as Administrative Agent and Collateral Agent, Lehman Brothers, Inc., as Syndication Agent, and Bear Stearns Corporate Lending, Inc. and UBS Securities LLC, as Co-Documentation Agents. (previously filed as Exhibit 10.1 to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.2	Amendment No. 1 to that certain Credit Agreement dated as of April 19, 2007, among United Surgical Partners International, Inc., USPI Holdings, Inc., as Borrower, the Lenders party thereto, Citibank, N.A., as Administrative Agent and Collateral Agent, Lehman Brothers, Inc., as Syndication Agent, and Bear Stearns Corporate Lending, Inc. and UBS Securities LLC, as Co-Documentation Agents (previously filed as Exhibit 99.1 to the Company's Current Report on Form 8-K filed with the Commission on August 20, 2009 and incorporated herein by reference).(1)

Exhibit Number	Description
10.3	Incremental Facility Amendment, dated as of April 3, 2012, among Holdings, the Company, the Incremental Lender (as defined therein), and JP Morgan Chase Bank, N.A., as Administrative Agent (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.4	Second Amendment, dated as of April 3, 2012, to the Credit Agreement dated as of April 19, 2007, among Holdings, the Company, as the Borrower, and the lenders, agents and other parties thereto (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.5	Third Amendment, dated as of December 19, 2012, to the Credit Agreement dated as of April 19, 2007, among Holdings, the Company, as the Borrower, and the lenders, agents and other parties thereto (previously filed as an exhibit to the Company's Current Report on Form 8-K filed with the Commission on December 19, 2012 and incorporated herein by reference).(1)
10.6	Fourth Amendment, dated as of February 19, 2013, to the Credit Agreement dated as of April 19, 2007, among Holdings, the Company, as the Borrower, and the lenders, agents and other parties thereto (previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the Commission on February 22, 2013 and incorporated herein by reference).(1)
10.7	Amendment No. 5, dated June 27, 2014, to the Credit Agreement, dated as of April 19, 2007, as amended August 19, 2009, April 3, 2012, December 19, 2012 and February 19, 2013 among USPI, USPI Holdings, Inc., each lender from time to time party thereto, JPMorgan Chase Bank, N.A., as Administrative Agent and the other Agents named therein (previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the Commission on July 10, 2014 and incorporated herein by reference).(1)
10.8	Guarantee and Collateral Agreement, dated as of April 19, 2007, among USPI Holdings, Inc., the Company, the subsidiaries of the Company identified therein and Citibank, N.A., as Collateral Agent (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.9	Employment Agreement, dated as of April 19, 2007, by and between the Company and Donald E. Steen (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.10	Amendment to Employment Agreement, dated as of November 14, 2011, by and between the Company and Donald E. Steen (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on March 2, 2012 and incorporated herein by reference).(1)(3)
10.11	Employment Agreement, dated as of April 19, 2007, by and between the Company and William H. Wilcox (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.12	Employment Agreement, dated as of April 19, 2007, by and between the Company and Brett P. Brodnax (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.13	Employment Agreement, dated as of April 21, 2009, by and between the Company and Philip A. Spencer. (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 25, 2011 and incorporated herein by reference).(1)(3)
10.14	Second Amended and Restated Employment Agreement, dated as of March 1, 2013, by and between the Company and Jason B. Cagle (previously filed as an exhibit to the Company's Current Report on Form 10-Q (No. 333-144337) and incorporated herein by reference).(1)(3)
10.15	Employment Agreement, dated as of January 7, 2013, by and between the Company and Sandra R. A. Karrmann.(2)(3)

Exhibit Number	Description
10.16	USPI Group Holdings, Inc. 2007 Equity Incentive Plan (previously filed as an exhibit to the Company's Quarterly Report on Form 10-Q (No. 333-144337) and incorporated herein by reference).(1)(3)
10.17	First Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 26, 2009 and incorporated herein by reference).(1)(3)
10.18	Second Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan.(1)(3)
10.19	Third Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan.(1)(3)
10.20	Fourth Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan.(2)(3)
10.21	Amended and Restated Deferred Compensation Plan (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 26, 2009 and incorporated herein by reference).(1)(3)
10.22	Form of Indemnification Agreement between United Surgical Partners International, Inc. and its directors and officers (previously filed as an exhibit to Amendment No. 1 to the Company's Registration Statement on Form S-1 (No. 333-55442) and incorporated herein by reference).(1)(3)
21.1	List of the Company's subsidiaries.(2)
24.1	Power of Attorney — Paul B. Queally(2)
24.2	Power of Attorney — Joel T. Allison(2)
24.3	Power of Attorney — Anthony F. Ecock(2)
24.4	Power of Attorney -- John C. Garrett, M.D.(2)
24.5	Power of Attorney — D. Scott Mackesy(2)
24.6	Power of Attorney — James Ken Newman(2)
24.7	Power of Attorney — Harold L. Paz, M.D., M.S.(2)
24.8	Power of Attorney — Raymond A. Ranelli(2)
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002(2)
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002(2)
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002(2)
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002(2)
101	The following materials from the Company's Annual Report on Form 10-K for the year ended December 31, 2014, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets at December 31, 2014 and December 31, 2013, (ii) Consolidated Statements of Income for the years ended December 31, 2014, 2013 and 2012, (iii) Consolidated Statements of Cash Flows for the years ended December 31, 2014, 2013 and 2012, (iv) Consolidated Statements of Comprehensive Income for the years ended December 31, 2014, 2013 and 2012, (v) Consolidated Statement of Changes in Equity for the years ended December 31, 2014, 2013 and 2012 and (iv) Notes to Consolidated Financial Statements.

(1) Previously filed.

(2) Filed herewith.

(3) Management contract or compensatory plan or arrangement in which a director or executive officer participates.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

UNITED SURGICAL PARTNERS INTERNATIONAL, INC.

By: /s/ WILLIAM H. WILCOX
William H. Wilcox
Chief Executive Officer and Director

Date: February 25, 2014

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in capacities and on the dates indicated.

Signature	Title	Date
*	Chairman of the Board	February 25, 2015
Paul B. Queally		
/s/ William H. Wilcox	Chief Executive Officer and Director (Principal Executive Officer)	February 25, 2015
William H. Wilcox		
/s/ Jason B. Cagle	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	February 25, 2015
Jason B. Cagle		
/s/ J. Anthony Martin	Senior Vice President, Corporate Controller And Chief Accounting Officer (Principal Accounting Officer)	February 25, 2015
J. Anthony Martin		
*	Director	February 25, 2015
Joel T. Allison		
*	Director	February 25, 2015
Anthony F. Ecock		
*	Director	February 25, 2015
John C. Garrett, M.D.		
*	Director	February 25, 2015
D. Scott Mackesy		
*	Director	February 25, 2015
James Ken Newman		

Signature	Title	Date
*	Director	February 25, 2015
Harold L. Paz, M.D., M.S.		
*	Director	February 25, 2015
Raymond A. Ranelli		

* W. Bradley Bickham, by signing his name hereto, does hereby sign this Annual Report on Form 10-K on behalf of each of the above-named directors and officers of the Company on the date indicated below, pursuant to powers of attorney executed by each of such directors and officers and contemporaneously filed herewith with the Commission.

By: /s/ W. Bradley Bickham
W. Bradley Bickham
Attorney-in-fact

Date: February 25, 2015

INDEX TO EXHIBITS

Exhibit Number	Description
2.1	Agreement and Plan of Merger dated as of January 27, 2006, by and among United Surgical Partners International, Inc., Peak ASC Acquisition Corp. and Surgis, Inc. (previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the Commission on January 31, 2006 and incorporated herein by reference).(1)
2.2	Agreement and Plan of Merger, dated as of January 7, 2007, by and among the Company, UNCN Holdings, Inc. and UNCN Acquisition Corp. (previously filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed with the Commission on January 8, 2007 and incorporated herein by reference).(1)
3.1	Amended and Restated Certificate of Incorporation (previously filed as Exhibit 3.1(A) to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)
3.2	Amended and Restated Bylaws (previously filed as Exhibit 3.1(B) to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)
4.1	Indenture, dated as of April 3, 2012 by and among USPI Finance Corp. and U.S. Bank National Association, as trustee (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.2	Supplemental Indenture, dated as of April 3, 2012, by and among the Company, the Subsidiary Guarantors named therein and U.S. Bank National Association, as trustee (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.3	Form of 9.000% Senior Notes due 2020 (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.4	Form of Notation of Subsidiary Guarantees (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.5	Registration Rights Agreement, dated April 3, 2012, by and between USPI Finance Corp. and Barclays Capital Inc., as representative of the several initial purchasers named therein (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
4.6	Registration Rights Agreement Joinder, dated as of April 3, 2012, by and between the Company, the Subsidiary Guarantors and Barclays Capital Inc., as representative of the several purchasers named therein (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.1	Credit Agreement, dated as of April 19, 2007, among USPI Holdings, Inc., the Company, as Borrower, the Lenders party thereto, Citibank, N.A., as Administrative Agent and Collateral Agent, Lehman Brothers, Inc., as Syndication Agent, and Bear Stearns Corporate Lending, Inc. and UBS Securities LLC, as Co-Documentation Agents. (previously filed as Exhibit 10.1 to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference)(1)
10.2	Amendment No. 1 to that certain Credit Agreement dated as of April 19, 2007, among United Surgical Partners International, Inc., USPI Holdings, Inc., as Borrower, the Lenders party thereto, Citibank, N.A., as Administrative Agent and Collateral Agent, Lehman Brothers, Inc., as Syndication Agent, and Bear Stearns Corporate Lending, Inc. and UBS Securities LLC, as Co-Documentation Agents (previously filed as Exhibit 99.1 to the Company's Current Report on Form 8-K filed with the Commission on August 20, 2009 and incorporated herein by reference).(1)

Exhibit Number	Description
10.3	Incremental Facility Amendment, dated as of April 3, 2012, among Holdings, the Company, the Incremental Lender (as defined therein), and JP Morgan Chase Bank, N.A., as Administrative Agent (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.4	Second Amendment, dated as of April 3, 2012, to the Credit Agreement dated as of April 19, 2007, among Holdings, the Company, as the Borrower, and the lenders, agents and other parties thereto (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.5	Third Amendment, dated as of December 19, 2012, to the Credit Agreement dated as of April 19, 2007, among Holdings, the Company, as the Borrower, and the lenders, agents and other parties thereto (previously filed as an exhibit to the Company's Current Report on Form 8-K filed with the Commission on December 19, 2012 and incorporated herein by reference).(1)
10.6	Fourth Amendment, dated as of February 19, 2013, to the Credit Agreement dated as of April 19, 2007, among Holdings, the Company, as the Borrower, and the lenders, agents and other parties thereto (previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the Commission on February 22, 2013 and incorporated herein by reference).(1)
10.7	Guarantee and Collateral Agreement, dated as of April 19, 2007, among USPI Holdings, Inc., the Company, the subsidiaries of the Company identified therein and Citibank, N.A., as Collateral Agent (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-183533) and incorporated herein by reference).(1)
10.8	Employment Agreement, dated as of April 19, 2007, by and between the Company and Donald E. Steen (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.9	Amendment to Employment Agreement, dated as of November 14, 2011, by and between the Company and Donald E. Steen (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on March 2, 2012 and incorporated herein by reference).(1)(3)
10.10	Employment Agreement, dated as of April 19, 2007, by and between the Company and William H. Wilcox (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.11	Employment Agreement, dated as of April 19, 2007, by and between the Company and Brett P. Brodnax (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.12	Employment Agreement, dated as of April 19, 2007, by and between the Company and Niels P. Vernegaard (previously filed as an exhibit to the Company's Registration Statement on Form S-4 (No. 333-144337) and incorporated herein by reference).(1)(3)
10.13	Second Amended and Restated Employment Agreement, dated as of September 1, 2012, by and between the Company and Mark A. Kopser (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 26, 2013 and incorporated herein by reference).(1)(3)
10.14	Employment Agreement, dated as of April 21, 2009, by and between the Company and Philip A. Spencer. (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 25, 2011 and incorporated herein by reference).(1)(3)
10.15	Second Amended and Restated Employment Agreement, dated as of March 1, 2013, by and between the Company and Jason B. Cagle (previously filed as an exhibit to the Company's Current Report on Form 10-Q (No. 333-144337) and incorporated herein by reference).(1)(3)

Exhibit Number	Description
10.16	USPI Group Holdings, Inc. 2007 Equity Incentive Plan (previously filed as an exhibit to the Company's Quarterly Report on Form 10-Q (No. 333-144337) and incorporated herein by reference).(1)(3)
10.17	First Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 26, 2009 and incorporated herein by reference).(1)(3)
10.18	Second Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan.(1)(3)
10.19	Third Amendment to the USPI Group Holdings, Inc. 2007 Equity Incentive Plan.(1)(3)
10.20	Amended and Restated Deferred Compensation Plan (previously filed as an exhibit to the Company's Current Report on Form 10-K filed with the Commission on February 26, 2009 and incorporated herein by reference).(1)(3)
10.21	Form of Indemnification Agreement between United Surgical Partners International, Inc. and its directors and officers (previously filed as an exhibit to Amendment No. 1 to the Company's Registration Statement on Form S-1 (No. 333-55442) and incorporated herein by reference).(1)(3)
21.1	List of the Company's subsidiaries.(2)
24.1	Power of Attorney — Paul B. Queally(2)
24.2	Power of Attorney — Joel T. Allison(2)
24.3	Power of Attorney — Anthony F. Ecock(2)
24.4	Power of Attorney — John C. Garrett, M.D.(2)
24.5	Power of Attorney — D. Scott Mackesy(2)
24.6	Power of Attorney — James Ken Newman(2)
24.7	Power of Attorney — Harold L. Paz, M.D., M.S.(2)
24.8	Power of Attorney — Raymond A. Ranelli(2)
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002(2)
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002(2)
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002(2)
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002(2)
101	The following materials from the Company's Annual Report on Form 10-K for the year ended December 31, 2014, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets at December 31, 2014 and December 31, 2013, (ii) Consolidated Statements of Income for the years ended December 31, 2014, 2013 and 2012, (iii) Consolidated Statements of Cash Flows for the years ended December 31, 2014, 2013 and 2012, (iv) Consolidated Statements of Comprehensive Income (Loss) for the years ended December 31, 2014, 2013 and 2011, (v) Consolidated Statement of Changes in Equity for the years ended December 31, 2014, 2013 and 2012 and (iv) Notes to Consolidated Financial Statements.

(1) Previously filed.

(2) Filed herewith.

(3) Management contract or compensatory plan or arrangement in which a director or executive officer participates.

EMPLOYMENT AGREEMENT

EMPLOYMENT AGREEMENT (this "Agreement") is made and entered into by and between United Surgical Partners International, Inc., a Delaware corporation (the "Company"), with its principal place of business at 15305 Dallas Parkway, Suite 1600, Addison, TX 75001-6491, and Sandra Karrmann af 2408 Hallow Hill Lane, Lewisville, Texas 75056 (the "Executive"), effective as of January 7, 2013 (the "Effective Date").

In consideration of the mutual promises, terms, provisions and conditions set forth in this Agreement, the parties hereby agrec as follows:

1. Employment. Subject to the terms and conditions set forth in this Agreement, the Company hereby offers and the Executive hereby accepts employment.

2. Term. The Company hereby agrees to employ Executive as Senior Vice President, Human Resources, and Executive hereby agrees to accept such employment, on the terms and conditions set forth herein, for the period commencing on the Effective Date and terminating as of and on the first anniversary of the Effective Date (unless sooner terminated as hereinafter set forth) (the "Term"); provided, however, that commencing on such first anniversary date, and each anniversary of the date hereaf thereafter, the Term of this Agreement shall automatically be extended for one additional year unless at least thirty (30) calendar days prior to each such anniversary date, the Company or Executive shall have given natice that it or she, as applicable, does not wish to extend this Agreement. Following the date on which the Executive's employment so terminates (the "Termination Date"), unless specifically otherwise agreed between Executive and the Company, the Executive shall cease to hold any position (whether as an officer, directar, manager, employee, trustee, fiduciary or otherwise) with the Company or any of its Subsidiaries (as defined in Section 13) or Affiliates (as defined in Section 13).

3. Capacity and Performance.

(a) During thc term uf Executive's employment hereunder, the Executive shall serve the Campany as its Senior Vice President, Human Resources, reparting to the Company's Chief Executive Officer. In addition, and without further compensation, the Executive shall serve as a directar and/or officer of one or more of the Company's Subsidiaries if so elected or appointed from time to time.

(b) During the term of Executive's emplayment hereunder, the Executive shall be employed by the Company on a full-time basis and shall perform such duties and responsibilities on behalf of thc Company and its Subsidiaries as may be designated from time to time by thc Chief Executive Officer.

(c) During the term of Executive's employment hereunder, thc Executive shall devote her full business time to the advancement of the business and interests of the Company and its Subsidiaries and to the discharge of her duties and responsibilitics hereunder. Thc Executive shall not engage in any other business activity or serve in any industry, trade, professional, governmental or academic position during the term of this Agreement, except as may be expressly approved in advance by the Chief Executive Officer in writing. Notwithstanding the preceding, the Executive may, without being in violation of the Executive's obligations hereunder, (i) serve on corporate, civic or charitable boards, or committees which are not engaged in business-competition with the Company and (ii) invest the Executive's personal assets in such form or manner as will not require any material services by the Executive in the operation af the entities in which such investments are made; provided that the Executive shall use the Executive's best efforts tu pursue such activities in such a manner so that such activities shall not prevent the Executive from fulfilling the Executive's obligations to the Campany hereunder.

4. Compensation and Benefits. During the Term, as compensation for all services performed by the Executive:

(a) Base Salary. The Company shall pay the Executive a base salary at the rate of Three Hundred Twenty-Five Thousand Dollars ($325,000) per year, payable in accordance with the payroll practices of the

Company for its executives and subject to increase from time to time by the Chief Executive Officer, in his sole discretion. Such base salary, as from time to time increased, is hereafter referred to as the "Base Salary."

(b) Bonus. During the Term, the Company may pay to the Executive such bonus payments, if any, as may be determined by the Board (as defined in Section 13) in its sole discretion, based upon the Executive's performance and other criteria as may be established by the Board from time to time. The "target" for Executive's annual bonus will be fifty percent (50%) of Base Salary. Notwithstanding the foregoing, Executive is guaranteed a minimum bonus in March 2014 of at least One Hundred Thousand Dollars ($100,000).

(c) Vacation. The Executive shall be entitled to vacation days as determined in accordance with the Company's vacation policy as in effect from time to time; provided, however, that for purposes of accrual under the Company's vacation policy, Executive will be treated as if she has been employed for ten years. For purposes of this Section 4(c), weekends shall not count as vacation days and Executive shall also be entitled to all paid holidays given by the Company to its senior executive officers. Vacation shall otherwise be governed by the policies of the Company, as in effect from time to time.

(d) Other Benefits. Subject to any contribution therefor generally required of executives of the Company, the Executive shall be entitled to participate in any and all employee benefit plans from time to time in effect for executives of the Company generally, except to the extent such plans are in a category of benefit specifically otherwise provided to the Executive under this Agreement *(e.g.,* severance pay). Such participation shall be subject to the terms of the applicable plan documents and generally applicable Company policies. The Board may alter, modify, add to or delete employee benefit plans at any time as it, in its sole judgment, determines to be appropriate.

(e) Business Expenses. The Company shall pay or reimburse the Executive for all reasonable and necessary business expenses incurred or paid by the Executive in the performance of her duties and responsibilities hereunder, subject to any maximum annual limit or other restrictions on such expenses set by the Board and to such reasonable substantiation and documentation as may be specified by the Company from time to time.

5. Termination of Employment. The Executive's employment hereunder shall terminate under the following circumstances:

(a) Death. In the event of the Executive's death during the Term, the Executive's employment shall immediately and automatically terminate.

(b) Disability. The Company may terminate the Executive's employment hereunder, upon notice to the Executive, in the event that the Executive becomes disabled during the Term through any illness, injury, accident or condition of either a physical or psychological nature and, as a result, is unable to satisfactorily perform her duties and responsibilities hereunder on a full-time basis, with or without reasonable accommodation, for ninety (90) days during any period of three hundred and sixty-five (365) consecutive calendar days. If any question shall arise as to whether during any period the Executive is disabled through any illness, injury, accident or condition of either a physical or psychological nature so as to be unable to perform substantially all of his duties and responsibilities hereunder, the Executive, at the request of the Company, shall submit to a medical examination by a physician selected by the Company to determine whether the Executive is so disabled and such determination shall for the purposes of this Agreement be conclusive of the issue. If such question shall arise and the Executive shall fail to submit to such medical examination, the Company's determination of the issue shall be binding on the Executive.

(c) By the Company for Cause. The Company may terminate the Executive's employment hereunder for Cause at any time upon notice to the Executive setting forth the nature of such Cause. The following shall constitute "Cause" for termination (in each case as determined by not less than seventy-five percent (75%) of the members of the Board): (i) the Executive's indictment for a felony or other crime involving

moral turpitude; (ii) the Executive's fraud, theft or embezzlement committed with respect to the Company or its Subsidiaries; (iii) material breach by the Executive of any of the provisions of Sections 7, 8 and/or 9 hereof; or (iv) the Executive's willful and continued failure to perform his material duties to the Company and its Subsidiaries.

(d) By the Company Other than for Cause. The Company may terminate the Executive's employment hereunder other than for Cause at any time upon notice to the Executive.

(e) By the Executive for Good Reason. At his option, Executive may terminate her employment hereunder for Good Reason (defined below). For purposes of this Agreement, the termination of Executive's employment hereunder by Executive because of the occurrence of any one or more of the following events shall be deemed to have occurred for "Good Reason":

(A) a material change in the nature or scope of Executive's authorities, status, powers, functions, duties, responsibilities, or reporting relationships that is determined by Executive in good faith to be adverse to those existing before such change;

(B) a material reduction in Executive's Base Salary that is not consented to or approved by Executive;

(C) a failure by the Company or any Subsidiary or Affiliate to comply with any other material term or provision hereof or of any other written agreement between Executive and the Company or any Subsidiary or Affiliate; or

(D) a refusal by the Executive upon a request by the Company to report for the performance of his services hereunder on a regular or permanent basis at any location or office more than fifty (50) miles from the Company's current address as described above in the preamble to this Agreement.

(f) By the Executive Other than for Good Reason. The Executive may terminate her employment hereunder other than for Good Reason pursuant to Section 5(e) above at any time upon the provision of ninety (90) days written notice to the Company. In the event of termination of the Executive pursuant to this Section 5(f), the Board may elect to waive the period of notice or any portion thereof.

6. Compensation Upon Termination.

(a) Death. In the event of a termination of the Executive's employment hereunder by reason of death as contemplated by Section 5(a), the Company shall pay in a lump sum within thirty (30) days of such termination to the Executive's designated beneficiary or, if no beneficiary has been designated by the Executive, to her estate, the Base Salary earned but not paid through the Termination Date.

(b) Disability. In the event of any termination of Executive's employment hereunder by reason of disability as contemplated by Section 5(b), the Company shall pay to him her Base Salary earned but not paid through the Termination Date.

(c) By the Company for Cause. In the event of any termination of Executive's employment hereunder by the Company for Cause as contemplated by Section 5(c), the Company shall have no further obligations to the Executive under this Agreement other than payment of Base Salary through the Termination Date.

(d) By the Company Other than for Cause or Upon Failure to Renew; By the Executive for Good Reason. In the event of any termination of Executive's employment hereunder by the Company other than for Cause pursuant to Section 5(d) or pursuant to Section 2 following notice that the Company does not wish to extend this Agreement for an additional one (1) year period, or by the Executive for Good Reason pursuant to Section 5(e), the Company shall (i) continue to pay the Executive the Base Salary at the rate in effect on the Termination Date for twelve (12) months, (ii) continue the Executive's health insurance benefits for twelve (12) months following the Termination Date (at a cost no less favorable than that paid by the Executive immediately prior to the Termination Date) or the economic equivalent thereof if such

continuation is not permissible under the terms of the Company's health insurance plan, and (iii) pay to the Executive a good faith estimate of the bonus the Executive would have received had the Executive remained employed by the Company through the end of the fiscal year in which the Termination Date occurred, as determined by the Company in its sole and absolute discretiun. Any such estimated bonus compensation shall be payable at such time or times as bonuses are payable to the other executives of the Company. Any obligation of the Company to the Executive pursuant to this Section 6(d) is conditioned upon (i) the Executive signing a release of claims in the form appended hereto as Attachment A (the "Employee Release") within twenty-one (21) days (or such greater period as the Company may specify) following the Termination Date and upon the Executive's not revoking the Employee Release in a timely manner thereafter and (ii) the Executive's continued full performance of his obligations hereunder, including those under Sections 7, 8 and/or 9 hereof. Base Salary to which the Executive is entitled under this Section 6(d) shall be payable in accordance with the normal payroll practices of the Company and will begin at the Company's next regular payroll period which is at least five business days following the effective date of the Employee Release, but shall be retroactive to the next business day following the Termination Date.

(e) By the Executive Other than for Good Reason. If the Executive shall terminate her employment pursuant to Section 5(f), the Company shall continue to pay Executive her Base Salary through the Termination Date (it being understood that if, in accordance with Section 5(f), the Board elects to waive the period of notice, or any portion thereof, the payment of Base Salary under this Section 6(e) shall continue through the notice period or any portion thereof so waived).

7. Restricted Activities. The Executive agrees that some restrictions on her activities during and after her employment are necessary to protect the goodwill, Confidential Information (as defined in Section 13) and other legitimate interests of the Company and its Subsidiaries:

(a) While the Executive is employed by the Company and for one (l) year from the later of the Termination Date or the last date on which the Executive receives a severance payment from the Company (in the aggregate, the "Non-Competition Period"), the Executive shall not, directly or indirectly, whether as owner, partner, investor, consultant, agent, employee, co-venturer or otherwise (other than through ownership of publiely-traded capital stock of a corporation which represents less than one percent (l%) of the outstanding capital stock of such corporation), (i) compete with the Company or any Subsidiary in any business activities, in the United States or in any other country, which the Company or uny Subsidiary shall conduct or intend to conduct as of the Termination Date, or (ii) undertake any planning for any business competitive with the Company or any of its Subsidiaries. Specifically, but without limiting the foregoing, the Executive agrees not to engage in any manner in any activity that is directly or indirectly competitive or potentially competitive with the business of the Company or any of its Subsidiaries as conducted or under consideration at any time during the Executive's employment with the Company (including prior to the date hereof).

(b) The Executive agrees that, during her employment with the Company, she will not undertake any outside activity, whether or not competitive with the business of the Company or its Subsidiaries, that could reasonably give rise to a conflict of interest or otherwise interfere with her duties and obligations to the Company or any of its Subsidiaries.

(c) The Executive further agrees that while she is employed by the Company and during the Non-Competition Period, the Executive will not, directly or indirectly, (i) hire or attempt to hire any employee of the Company or any of its Subsidiaries or anyone who was such an employee within the six (6) months preceding such hire or attempt to hire, (ii) hire or attempt to hire any independent contractor providing services to the Company or any of its Subsidiaries or anyone who was such an independent contractor within six (6) months preceding such hire or attempt to hire, (iii) assist in hiring or any attempt to hire of anyone identified in clauses (i) or (ii) of this sentence by any other Person (as defined in Section 13), (iv) encourage any employee or independent contractor of the Company or any of its Subsidiaries to terminate his relationship with the Company or any of its Subsidiaries, or (v) solicit or encourage any customer or vendor of the Company or any of its Subsidiaries (including physicians holding clinical

privileges at any surgical facility in which the Company has a direct or indirect ownership interest or with which a Subsidiary has a management agreement) to terminate or diminish its relationship with any of them, or, in the case of a customer, to conduct with any Person any business or activity which such customer conducts or could conduct with the Company or any of its Subsidiaries.

8. Confidential Information.

(a) The Executive acknowledges that the Company and its Subsidiaries continually develop Confidential Information, that the Executive may in the future develop Confidential Information for the Company or its Subsidiaries and that the Executive may in the future learn of Confidential Information during the course of employment with the Company. The Executive will comply with the policies and procedures of the Company and its Subsidiaries for protecting Confidential Information and shall never use or disclose to any Person (except as required by applicable law or for the proper performance of his duties and responsibilities to the Company and its Subsidiaries), any Confidential Information obtained by the Executive incident to her employment or other association with the Company or any of its Subsidiaries. The Executive understands that this restriction shall continue to apply after her employment terminates, regardless of the reason for such termination.

(b) All documents, records, tapes and other media of every kind and description relating to the business, present or otherwise, of the Company or its Subsidiaries and any copies, in whole or in part, thereof (the "Documents"), whether or not prepared by the Executive, shall be the sole and exclusive property of the Company and its Subsidiaries. The Executive shall safeguard all Documents and shall surrender to the Company at the time his employment terminates, or at such earlier time or times as the Board or its designee may specify, all Documents then in the Executive's possession or control.

9. Assignment of Rights to Intellectual Property. The Executive shall promptly and fully disclose all Intellectual Property (as defined in Section 13) to the Company. The Executive hereby assigns and agrees to assign to the Company (or as otherwise directed by the Company) the Executive's full right, title and interest in and to all Intellectual Property. The Executive agrees to execute any and all applications for domestic and foreign patents, copyrights or other proprietary rights and to do such other acts (including without limitation the execution and delivery of instruments of further assurance or confirmation) requested by the Company to assign the Intellectual Property to the Company and to permit the Company to enforce any patents, copyrights or other proprietary rights to the Intellectual Property. The Executive will not charge the Company for time spent in complying with these obligations. All copyrightable works that the Executive creates shall be considered "work made for hire."

10. Notification Requirement. Until the conclusion of the Non-Competition Period, the Executive shall give notice to the Company of each new business activity that she plans to undertake at least thirty (30) days prior to beginning any such activity. Such notice shall state the name and address of the Person for whom such activity is undertaken and the nature of the Executive's business relationship(s) and position(s) with such Person. The Executive shall provide the Company with such other pertinent information concerning such business activity as the Company may reasonably request in order to determine the Executive's continued compliance with his obligations under Sections 7, 8 and/or 9 hereof.

11. Enforcement of Covenants. The Executive acknowledges that she has carefully read and considered all the terms and conditions of this Agreement, including the restraints imposed upon her pursuant to Sections 7, 8 and/or 9 hereof. The Executive agrees that said restraints are necessary for the reasonable and proper protection of the Company and its Subsidiaries and that each and every one of the restraints is reasonable in respect to subject matter, length of time and geographic area. The Executive further acknowledges that, were she to breach any of the covenants contained in Sections 7, 8 and/or 9 hereof, the damage to the Company would be irreparable. The Executive therefore agrees that the Company, in addition to any other remedies available to it, shall be entitled to preliminary and permanent injunctive relief against any breach or threatened breach by the

Executive of any of said covenants, without having to post bond. The parties further agree that, in the event that any provision of Sections 7, 8 and/or 9 hereof shall be determined by any court of competent jurisdiction to be unenforceable by reason of its being extended over too great a time, too large a geographic area or too great a range of activities, such provision shall be deemed to be modified to permit its enforcement to the maximum extent permitted by law.

12. Conflicting Agreements. The Executive hereby represents and warrants that the execution of this Agreement and the performance of his obligations hereunder will not breach or be in conflict with any other agreement to which the Executive is a party or is bound and that the Executive is not now subject to any covenants against competition or similar covenants or any court order or other legal obligation that would affect the performance of his obligations hereunder. The Executive will not disclose to or use on behalf of the Company any proprietary information of a third party without such party's consent.

13. Definitions. Words or phrases which are initially capitalized or are within quotation marks shall have the meanings provided in this Section 13 and as provided elsewhere herein. For purposes of this Agreement, the following definitions apply:

(a) "Affiliate" means, with respect to the Company or any other specified Person, any other Person directly or indirectly controlling, controlled by or under common control with the Company or such other specified Person, where control may be by management authority, equity interest or other means.

(b) "Board" means the board of directors of the Company.

(c) "Confidential Information" means any and all information of the Company and its Subsidiaries that is not generally known by others with whom they compete or do business, or with whom they plan to compete or do business and any and all information which, if disclosed by the Company or its Subsidiaries, would assist in competition against them. Confidential Information includes without limitation such information relating to (i) the development, research, testing, manufacturing, marketing and financial activities of the Company and its Subsidiaries, (ii) the Products, (iii) the costs, sources of supply, financial performance and strategic plans of the Company and its Subsidiaries, (iv) the identity and special needs of the customers of the Company and its Subsidiaries and (v) the people and organizations with whom the Company and its Subsidiaries have business relationships and those relationships. Confidential Information also includes any information that the Company or any of its Subsidiaries have received, or may receive hereafter, from others which was received by the Company or any of its Subsidiaries with any understanding, express or implied, that the information would not be disclosed.

(d) "Intellectual Property" means inventions, discoveries, developments, methods, processes, compositions, works, concepts and ideas (whether or not patentable or copyrightable or constituting trade secrets) conceived, made, created, developed or reduced to practice by the Executive (whether alone or with others and whether or not during normal business hours or on or off the premises of the Company or any of its Subsidiaries) during the Executive's employment with the Company or any of its Subsidiaries (including prior to the Effective Date) that relate to either the Products or any prospective activity of the Company or any of its Subsidiaries or that make use of Confidential Information or any of the equipment or facilities of the Company or any of its Subsidiaries.

(e) "Person" means an individual, a corporation, a limited liability company, an association, a partnership, an estate, a trust and any other entity or organization.

(f) "Products" mean all products planned, researched, developed, tested, manufactured, sold, licensed, leased or otherwise distributed or put into use by the Company or any of its Subsidiaries, together with all services provided or planned by the Company or any of its Subsidiaries, during the Executive's employment with the Company or any of its Subsidiaries (including prior to the Effective Date).

(g) "Subsidiary" shall mean any Person of which the Company (or other specified Person) shall, directly or indirectly, own beneficially or control the voting of at least a majority of the outstanding capital stock (or other shares of beneficial interest) entitled to vote generally or at least a majority of the

partnership, membership, joint venture or similar interests, or in which the Company (or other specified Person) or a Subsidiary thereof shall be a general partner or joint venturer without limited liability.

14. Survival. The pruvisions of this Agreement shall survivc following the Termination Date if so provided herein or desirable to accomplish the purposes of uther surviving provisions, including without limitation the provisions of Sections 6, 7, 8 and 9 hereof.

15. Withholding. All payments made by the Company under this Agreement shall be reduced by any tax or other amounts required to be withheld by the Company under applicable law.

16. Assignment. Neither the Company nor the Executive may make any assignment of this Agreement or any interest herein, by operation of law or otherwise, without the prior written consent of the other; provided, however, that the Company may assign its rights and obligations under this Agreement without the consent of the Executive in the cvent that the Company shall hereafter effect a reorganization, consolidation or merger or in the event the Company transfers all or substantially all of its properties or assets. This Agreement shall inure to the benefit of and be binding upon the Company and the Executive, their respective succcssors, executors, administrators, heirs and permitted assigns.

17. Severability. If any portion or provision of this Agreement shall to any extent be declared illegal or unenforceable by a court of competent jurisdiction, then the remainder of this Agreement, or the application of such portion or provision in circumstances other than those as to which it is so declared illegal or unenforceable, shall not be affected thereby, and each portion and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

18. Waiver. No waiver of any provision hereof shall be effective unless made in writing and signed by the waiving party. The failure of either party to require the performance of any term or obligation of this Agreement, or the waiver by either party of any breach of this Agreement, shall not prevent any subsequent enforcement of such term or obligation or be deemed a waiver of any subsequent breach.

19. Notices. Any and all notices, requests, demands and other communications provided for by this Agreement shall be in writing and shall be effective when delivered in person, when delivered by courier at the Executive's last known address on the books of the Company, or three business days following deposit in the United States mail, postage prepaid, registered or certified, and addressed to the Executive at his last known address on the books of the Company or, in the case of the Company, at its principal place of business, attention of the Chairman of the Board, or to such other address as either party may specify by notice to the other actually received.

20. Entire Agreement. This Agreement and the other plans and documents specifically referred to herein constitute the entire agreement between the parties regarding the subject matter of this Agreement and such other plans and documents and supersede all prior communications, agreements and understandings, written or oral, with respect to such subject matter.

21. Amendment. This Agreement may be amended or modified only by a written instrument signed by the Executive and by an expressly authorized representative of the Company.

22. Headings. The headings and captions in this Agreement are for convenience only and in no way define or describe the scope or content of any provision of this Agreement.

23. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be an original and all of which together shall constitute one and the same instrument.

24. Governing Law. This contract and shall be construed and enforced under and be governed in all respects by the laws of Texas, without regard to the conflict of laws principles thereof.

IN WITNESS WHEREOF, this Agreement has been executed as of the date first above written.

THE EXECUTIVE:

Sandra Karrmann

UNITED SURGICAL PARTNERS INTERNATIONAL, INC.

By:
Name: William H. Wilcox
Title: CEO

RELEASE OF CLAIMS

FOR AND IN CONSIDERATION OF the special payments and benefits to be provided in connection with the termination of my employment in accordance with the terms of the Employment Agreement between me and UNITED SURGICAL PARTNERS INTERNATIONAL, INC., a Delaware corporation (the "Company") dated as of January 7, 2013 (the "Employment Agreement"), I, on my own behalf and on behalf of my personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees and all others connected with me, hereby release and forever discharge, the Company, its Subsidiaries and Affiliates and all of their respective past and present officers, directors, stockholders, members, partners, managers, controlling persons, employees, agents, representatives, successors and assigns and all others connected with any of them (all collectively, the "Released"), both individually and in their official capacities, from any and all rights, liabilities, claims, demands and causes of action of any type (all collectively "Claims") which I have had in the past, now have, or might now have, through the date of my signing of this Release of Claims, in any way resulting from, arising out of or connected with my employment or its termination or pursuant to any federal, state, foreign or local employment law, regulation or other requirement (including without limitation Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Americans with Disabilities Act, and the fair employment practices laws of the state or states in which I have been employed pursuant to the Employment Agreement, each as amended from time to time); provided, however, that the foregoing release shall not apply to any right or benefit that Section 6 of the Employment Agreement explicitly provides shall survive the termination of my employment. Capitalized terms used in this Release of Claims that are defined in the Employment Agreement are used herein with the meanings so defined.

In signing this Release of Claims, I acknowledge that I have had at least twenty-one (21) days from the date of notice of termination of my employment to consider the terms of this Release of Claims and that such time has been sufficient, that I am encouraged by the Company to seek the advice of an attorney prior to signing this Release of Claims and that I am signing this Release of Claims voluntarily and with a full understanding of its terms.

I understand that I may revoke this Release of Claims at any time within seven (7) days of the date of my signing by written notice to the Company and that this Release of Claims will take effect only upon the expiration of such seven-day revocation period and only if I have not timely revoked it.

Intending to be legally bound, I have signed this Release of Claims as of the date written below.

Signature: _____
Sandra Karmann

Date: _____

FOURTH AMENDMENT TO THE
USPI GROUP HOLDINGS, INC.
2007 EQUITY INCENTIVE PLAN

This Fourth Amendment (this "Amendment") is entered into to be effective as of July 15, 2014 (the "Effective Date"). All capitalized terms used but not defined herein shall have the meaning ascribed to such terms in the USPI Group Holdings, Inc. 2007 Equity Incentive Plan (as amended, the "Plan").

WITNESSETH:

WHEREAS, USPI Group Holdings, Inc., a Delaware corporation (the "Company"), has adopted the Plan to advance the interests of the Company by providing for the grant to Participants of Awards.

WHEREAS, pursuant to Section 9 of the Plan, the Administrator may amend the Plan;

WHEREAS, Section 4(a) of the Plan initially provided that a maximum of 20,145,458 shares of Stock may delivered in satisfaction of Awards under the Plan;

WHEREAS, the First Amendment to the Plan increased the maximum shares of Stock that may be delivered in satisfaction of Awards under the Plan to 20,726,523;

WHEREAS, the Second Amendment to the Plan increased the maximum shares of Stock that may be delivered in satisfaction of Awards under the Plan to 26,630,457;

WHEREAS, the Third Amendment to the Plan increased the maximum shares of Stock that may be delivered in satisfaction of Awards under the Plan to 27,070,457; and

WHEREAS, the Administrator again desires to amend Section 4(a) of the Plan as set forth in this Amendment.

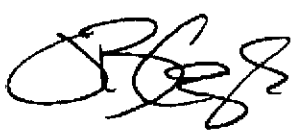
NOW, THEREFORE, the Plan is hereby amended, effective as of the Effective Date, as follows:

1. The first sentence of Section 4(a) of the Plan is hereby amended in its entirety to read as follows: "A maximum of 31,816,215 shares of Stock may be delivered in satisfaction of Awards under the Plan."

2. Except as modified by this Amendment, the Plan shall continue to read in its current state.

IN WITNESS WHEREOF, the undersigned, being the duly elected Secretary of the Company, hereby certifies that this Amendment was adopted by the Administrator on the Effective Date.

USPI GROUP HOLDINGS, INC.



By:
Name: Jason B. Cagle
Title: Chief Financial Officer

SUBSIDIARIES

NAME	STATE INCORPORATED
25 East Same Day Surgery, L.L.C.	IL
Advanced Ambulatory Surgical Care, L.P. (d/b/a Advanced Surgical Care)	MO
Adventist Midwest Health/USP Surgery Centers, L.L.C.	IL
AIG Holdings, LLC	TX
AIGB Austin, LP	TX
AIGB Global, LLC	TX
AIGB Group, Inc.	DE
AIGB Holdings, Inc.	DE
AIGB Management Services, LLC	TX
Alamo Heights Surgicare, L.P. (d/b/a Alamo Heights Surgery Center)	TX
Alliance Greenville Texas General Partner, LLC	DE
Alliance Sterling Ridge, L.P.	DE
Alliance Surgery Birmingham, LLC	DE
Alliance Surgery, Inc. (d/b/a Texas ASI, Inc.)	DE
Ambulatory Surgical Associates, LLC (d/b/a Tullahoma Surgery Center)	TN
Ambulatory Surgical Center of Somerville, LLC (d/b/a Somerset Ambulatory Surgical Center)	NJ
American Institute of Gastric Banding Phoenix, Limited Partnership	AZ
American Institute of Gastric Banding, Ltd. (d/b/a 1)AIGB Diagnostics 2) Turning Point Specialty Surgery Center)	TX
APN (d/b/a Arlington Physicians Network)	TX
Arlington Orthopedic and Spine Hospital, LLC (d/b/a Baylor Orthopedic and Spine Hospital at Arlington)	TX
Arlington Surgicare Partners, Ltd. (d/b/a Baylor Surgicare at Arlington)	TX
ASC Coalition, Inc.	DE
Bagley Holdings, LLC	OH
Baptist Plaza Surgicare, L.P.	TN
Baptist Surgery Center, L.P.	TN
Baptist Women's Health Center, LLC (d/b/a Saint Thomas Hospital for Specialty Surgery (f/k/a Saint Thomas Hospital for Spinal Surgery))	TN
Baptist/USP Surgery Centers, L.L.C.	TX
Baylor Surgicare at Ennis, LLC	TX
Baylor Surgicare at Granbury, LLC	TX
Baylor Surgicare at Mansfield, LLC	TX
Baylor Surgicare at Plano Parkway, LLC	TX
Baylor Surgicare at Plano, LLC (d/b/a Baylor Surgicare at Plano)	TX
Beaumont Surgical Affiliates, Ltd. (d/b/a Baptist Beaumont Surgical Affiliates)	TX
Bellaire Outpatient Surgery Center, L.L.P. (d/b/a Baylor Surgicare at Oakmont)	TX
Bloomington ASC, LLC (d/b/a Indiana Specialty Surgery Center)	IN
Bon Secours Surgery Center at Harbour View, LLC	VA
Bon Secours Surgery Center at Virginia Beach, LLC	VA
BremnerDuke Mary Shiels Development, L.P.	IN
Briarcliff Ambulatory Surgery Center, L.P. (d/b/a Briarcliff Surgery Center)	MO
Cascade Spine Center, LLC	DE
Castle Rock Surgery Center, LLC	CO
Cedar Park Surgery Center, L.L.P. (d/b/a Hill Country Surgery Center)	TX
Central Jersey Surgery Center, LLC	GA
Central Virginia Surgi-Center, L.P. (d/b/a Surgi-Center of Central Virginia)	VA
Chandler Endoscopy Ambulatory Surgery Center, LLC (d/b/a Chandler Endoscopy Center)	AZ

NAME	STATE INCORPORATED
Chattanooga Pain Management Center, LLC (d/b/a Chattanooga Pain Surgery Center)	DE
Chesterfield Ambulatory Surgery Center, L.P. (d/b/a Chesterfield Surgery Center)	MO
Chico Surgery Center, LP	CA
Christus Cabrini Surgery Center, L.L.C.	LA
Clarkston ASC Partners, LLC (d/b/a Clarkston Surgery Center)	MI
Clarksville Surgery Center, LLC (d/b/a St. Thomas Surgery Center Clarksville)	TN
Coast Surgery Center, L.P. (d/b/a Coast Surgery Center of South Bay)	CA
Corpus Christi Surgicare, Ltd. (d/b/a 1)CHRISTUS Spohn - Corpus Christi Outpatient Surgery 2)Corpus Christi Outpatient Surgery Center)	TX
Creekwood Surgery Center, L.P.	MO
Crown Point Surgery Center, LLC (d/b/a Crown Point Surgery Center)	CO
CS/USP General Partner, LLC	TX
CS/USP Surgery Centers, LP	TX
Dallas Surgical Partners, LLC (d/b/a 1)Baylor Surgicare 2)Physicians Daysurgery Center)	TX
Day-Op Surgery Consulting Company, LLC (d/b/a 1)USP Administrative Subsidiary 2)Day-Op Consulting)	DE
Denton Surgicare Partners, Ltd. (d/b/a Baylor Surgicare at Denton)	TX
Denton Surgicare Real Estate, Ltd.	TX
Denville Surgery Center, LLC (d/b/a 1) Orthopaedic Surgery Center of Northwest Jersey 2) Surgical Center of Northwest Jersey)	NJ
Desert Ridge Outpatient Surgery, LLC	AZ
Desoto Surgicare Partners, Ltd. (d/b/a North Texas Surgery Center)	TX
Destin Surgery Center, LLC	FL
DH UAP, LLC	TX
Dignity/USP Folsom GP, LLC	CA
Dignity/USP Grass Valley GP, LLC	CA
Dignity/USP Las Vegas Surgery Centers, LLC	NV
Dignity/USP Metro Surgery Center, LLC	AZ
Dignity/USP NorCal Surgery Centers, LLC	CA
Dignity/USP Oxnard Surgery Centers, LLC	CA
Dignity/USP Phoenix Surgery Centers, LLC	AZ
Dignity/USP Redding GP, LLC	CA
Dignity/USP Roseville GP, LLC	CA
Doctors Outpatient Surgicenter, Ltd. (d/b/a Doctors Outpatient Surgicenter)	TX
Dreamland UAP Anesthesia, LLC	MO
East Portland Surgery Center, LLC	OR
East West Surgery Center, L.P.	GA
Eastgate Building Center, L.L.C.	OH
Effingham Surgical Partners, LLC (d/b/a Effingham Ambulatory Surgery Center)	IL
Einstein Montgomery Surgery Center, LLC	PA
Einstein/USP Surgery Centers, L.L.C.	PA
El Mirador Surgery Center, LLC	CA
Elite Anesthesia, LLC	AZ
Encinitas Endoscopy Center, LLC (d/b/a The Endoscopy Center)	CA
Endoscopy Center of Hackensack, LLC (d/b/a Hackensack Endoscopy Center)	NJ
Eye Center of Nashville UAP, LLC	TN
Eye Surgery Center of Nashville, LLC (d/b/a Anesthesia Services of ESCN)	TN
Flatirons Surgery Center, LLC (d/b/a Ambulatory Surgery Centers, Inc.)	CO
Folsom Outpatient Surgery Center, L.P. (d/b/a Folsom Surgery Center)	CA
Fort Worth Hospital Real Estate, L.P.	TX
Fort Worth Surgicare Partners, Ltd. (d/b/a 1)Baylor Surgical Hospital at Fort Worth 2)Medical Centre Surgical Hospital 3)Baylor Surgical Hospital at Fort Worth Outpatient Center)	TX

NAME	STATE INCORPORATED
FPN - FRISCO PHYSICIANS NETWORK (d/b/a Frisco Physicians Network)	TX
Franklin Endo UAP, LLC	TN
Franklin Endoscapy Center, LLC (d/b/a Franklin Surgery Center)	TN
Frisco Medical Center, L.L.P. (d/b/a Baylor Medical Center at Frisca)	TX
Frontenac Ambulatory Surgery & Spine Care Center, L.P. (d/b/a Frontenac Surgery & Spine Care Center)	MO
Gallatin Physician Realty Partners, LLC	TN
Gamma Surgery Center, LLC	DE
Garland Surgicare Partners, Ltd. (d/b/a Baylor Surgicare at Garland)	TX
Gateway Endoscapy Center, L.P. (d/b/a Gateway Endoscopy Center)	MO
Genesis ASC Partners, LLC (d/b/a Genesis Surgery Center)	MI
Geargia Musculoskeletal Network, Inc.	GA
GLS UAP Sugarland, LLC	TX
Grapevine Surgicare Partners, Ltd. (d/b/a Baylor Surgicare at Grapevine)	TX
Grass Valley Outpatient Surgery Center, L.P. (d/b/a Grass Valley Surgery Center)	CA
Greenville Physicians Surgery Center, LLP	TX
Greenwood ASC, LLC (d/b/a Greenwood Ambulatory Surgery Center)	DE
Hacienda Outpatient Surgery Center, LLC (d/b/a Hacienda Surgery Center)	CA
Harvard Park Surgery Center, LLC (d/b/a Harvard Park Surgery Center)	CO
Hazelwaod Endascopy Center, LLC (d/b/a Endoscopy & Calonoscopy Center)	MO
HCH/USP Surgery Centers, LLC	FL
Health Horizons of Kansas City, Inc.	TN
Health Harizons of Murfreesboro, Inc.	TN
Healthmark Partners, Inc.	DE
Hershey Outpatient Surgery Center, L.P.	PA
Hinsdale Surgical Center, LLC	IL
HMHP/USP Surgery Centers, LLC	OH
Hauston Ambulatary Surgical Associates, L.P.	TX
Hauston PSC, L.P. (d/b/a 1)Physicians Surgicenter of Houston True Results 2)Physicians Surgicenter of Houston)	TX
HUMC/USP Surgery Centers, LLC	NJ
ICNU Rockford, LLC	IL
Implant Solutions, LLC	TN
Irving-Coppell Surgical Haspital, L.L.P. (d/b/a 1)Irving Coppell Surgical Hospital 2)Baylor Surgical Hospital at Las Colinas)	TX
Jackson Surgical Center, LLC (d/b/a Jackson Surgery Center)	NJ
JFP UAP Sugarland, LLC	TX
KHS Ambulatory Surgery Center LLC (d/b/a Select Surgical Center at Kennedy)	NJ
KHS/USP Surgery Centers, LLC	NJ
Lake Lansing ASC Partners, LLC (d/b/a Lansing Surgery Center)	MI
Lakewoad Surgery Center, LLC	DE
Lansing ASC Partners, LLC	MI
Lawrenceville Surgery Center, L.L.C.	GA
Lebanon Endoscapy Center, LLC (d/b/a Anesthesia Services of Lebanon)	TN
Lee's Summit Endo UAP, LLC	MO
Legacy/USP Surgery Centers, L.L.C.	OR
Legacy Warren Partners, L.P.	TX
Lewisville Surgicare Partners, Ltd. (d/b/a Baylor Surgicare at Lewisville)	TX
Liberty Ambulatory Surgery Center, L.P.	MO
Liberty Ambulatory Surgery Center, LLC	NJ
Liberty/USP Surgery Centers, L.L.C.	NJ

NAME	STATE INCORPORATED
Lone Star Endoscopy Center, LLC (d/b/a 1)Lone Star Endoscopy 2)Lone Star Endoscopy Flower Mound)	TX
Manchester Ambulatory Surgery Center, LP (d/b/a Manchester Surgery Center)	MO
Mary Immaculate Ambulatory Surgery Center, LLC	VA
Mason Ridge Ambulatory Surgery Center, L.P. (d/b/a Mason Ridge Surgery Center)	MO
McLaren ASC of Flint, LLC	MI
MCSH Real Estate Investors, Ltd.	TX
Medical Park Tower Surgery Center, LLC	TX
MedPlex Outpatient Surgery Center, Ltd.	AL
MEDSTAR/USP Surgery Centers, L.L.C.	MD
Memorial Hermann Bay Area Endoscopy Center, LLC (d/b/a Bay Area Endoscopy)	TX
Memorial Hermann Endoscopy & Surgery Center North Houston, LLC (d/b/a 1)Memorial Hermann Endoscupy & Surgery Center North Houston 2)North Houston Endoscopy & Surgery)	TX
Memorial Hermann Endoscopy Center North Freeway, LLC (d/b/a Memorial Hermann Endoscopy Center North Loop)	TX
Memorial Hermann Specialty Hospital Kingwood, L.L.C. (d/b/a Memorial Hermann Surgical Hospital Kingwood)	TX
Memorial Hermann Sugar Land Surgical Hospital, LLP (d/b/a 1)Surgical Specialty Hospital of Sugar Land, LLP, an affiliate of Memorial Hermann 2)Memorial Hermann Surgical Hospital First Colony)	TX
Memorial Hermann Surgery Center - The Woodlands, LLP	TX
Memorial Hermann Surgery Center Katy, LLP	TX
Memorial Hermann Surgery Center Kingsland, L.L.C. (d/b/a Memorial Hermann Surgery Center Kingsland)	TX
Memorial Hermann Surgery Center Kirby, LLC	TX
Memorial Hermann Surgery Center Memorial City, LLC (d/b/a Memorial Hermann Memorial Village Surgery Center)	TX
Memorial Hermann Surgery Center Northwest LLP	TX
Memorial Hermann Surgery Center Richmond, LLC (d/b/a Memorial Hermann Surgery Center Richmond)	TX
Memorial Hermann Surgery Center Southwest, L.L.P.	TX
Memorial Hermann Surgery Center Sugar Land, L.L.P.	TX
Memorial Hermann Surgery Center Texas Medical Center, LLP	TX
Memorial Hermann Surgery Center Woodlands Parkway, LLC (d/b/a Memorial Hermann Surgery Center Woodlands Parkway)	TX
Memorial Hermann Texas International Endoscopy Center, LLC (d/b/a Texas International Endoscopy Center)	TX
Memorial Hermann/USP Surgery Centers II, LP	TX
Memorial Hermann/USP Surgery Centers III, LLP	TX
Memorial Hermann/USP Surgery Centers IV, LLP	TX
Memorial Hermann/USP Surgery Centers, LLP	TX
Memorial Surgery Center, LLC (d/b/a Tulsa Surgery Center)	OK
Mercy/USP Health Ventures, L.L.C.	IA
Metro Surgery Center, LLC	DE
Metrocrest Surgery Center, L.P. (d/b/a Baylor Surgicare at Carrollton)	TX
Metroplex Surgicare Partners, Ltd. (d/b/a Baylor Surgicare at Bedford)	TX
Metropolitan New Jersey, LLC (d/b/a Metropolitan Surgery Center)	NJ
MH Memorial City Surgery, LLC	TX
MH/USP Bay Area, LLC	TX
MH/USP Kingsland, LLC	TX
MH/USP Kingwood, LLC	TX

NAME	STATE INCORPORATED
MH/USP Kirby, LLC	TX
MH/USP North Freeway, LLC	TX
MH/USP North Houston, LLC	TX
MH/USP Richmond, LLC	TX
MH/USP Sugar Land, LLC	TX
MH/USP TMC Endoscopy, LLC	TX
MH/USP West Houston, L.L.C.	TX
MH/USP Woodlands Parkway, LLC	TX
Michigan ASC Partners, L.L.C.	MI
Mid Rivers Ambulatory Surgery Center, L.P. (d/b/a Mid Rivers Surgery Center)	MO
Mid State Endo UAP, LLC	TN
Middle Tennessee Ambulatory Surgery Center, L.P.	DE
Midland Memorial/USP Surgery Centers, LLC	TX
Midland Texas Surgical Center, LLC (d/b/a 1)Texas Surgical Center, an affiliate of Midland Memorial Hospital 2)Texas Surgical Center)	TX
Mid-State Endoscopy Center, LLC (d/b/a Anesthesia Services of Mstate)	TN
Midwest Digestive Health Center, LLC (d/b/a 1)Midwest Physicians Surgery Center 2)Anesthesia Services of Midwest)	MO
Millennium Surgical Center, LLC	NJ
Mountain Empire Surgery Center, L.P.	GA
MSH Partners, LLC (d/b/a 1)Mary Shiels Hospital 2)Baylor Medical Center at Uptown)	TX
New Horizons Surgery Center, LLC	OH
New Mexico Orthopaedic Surgery Center, L.P.	GA
NKCH/USP Briarcliff GP, LLC	MO
NKCH/USP Liberty GP, LLC	MO
NKCH/USP Surgery Centers II, L.L.C.	MO
NKCH/USP Surgery Centers, LLC	MO
North Central Surgical Center, L.L.P. (d/b/a North Central Surgical Center)	TX
North Garland Surgery Center, L.L.P. (d/b/a Baylor Surgicare at North Garland)	TX
North Haven Surgery Center, LLC	CT
North Shore Same Day Surgery, L.L.C. (d/b/a North Shore Surgical Center)	IL
North State Surgery Centers, L.P. (d/b/a Court Street Surgery Center, Mercy Surgery Center and Redding Surgery Center)	CA
Northern Monmouth Regional Surgery Center, L.L.C.	NJ
Northridge Surgery Center, L.P.	TN
NorthShore/USP Surgery Centers II, L.L.C.	IL
Northwest Ambulatory Surgery Center, LLC (d/b/a 1)Northwest Surgery Center 2)Northwest Ambulatory Surgery Center)	OR
Northwest Georgia Orthopaedic Surgery Center, LLC	GA
Northwest Regional ASC, LLC	DE
Northwest Surgery Center, LLP	TX
NSCH/USP Desert Surgery Centers, LLC	DE
OCOMS Imaging, LLC	OK
OCOMS Professional Services, LLC	OK
Oklahoma Center for Orthopedic and Multi-Specialty Surgery, LLC	OK
Old Tesson Surgery Center, L.P.	MO
Olive Ambulatory Surgery Center, L.P. (d/b/a Olive Surgery Center)	MO
OLOL Pontchartain Surgery Center, LLC (d/b/a Our Lady of the Lake Surgery Center Pontchartrain)	LA
OLOL/USP Surgery Centers, L.L.C.	TX
Orlando Health/USP Surgery Centers, L.L.C.	FL
OrthoLink ASC Corporation	TN

NAME	STATE INCORPORATED
OrthoLink Physicians Corporation	DE
OrthoLink Radiology Services Corporation	TN
OrthuLink/ Georgia ASC, Inc.	GA
OrthoLink/Baptist ASC, LLC	TN
OrthoLink/New Mexico ASC, Inc.	GA
Orthopedic and Surgical Specialty Company, LLC (d/b/a 1)Arizona Orthopedic Surgical Hospital 2)Arizona Orthopedic and Surgical Specialty Hospital)	AZ
Orthopedic South Surgical Partners, LLC (d/b/a Orthopedics South Surgical Center)	GA
Pacific Endo-Surgical Center, L.P.	CA
PAHS/USP Surgery Centers, LLC	CO
Pain Diagnostic and Treatment Center, L.P.	CA
Pain Treatment Centers of Michigan, LLC (d/b/a Matrix Surgery Center)	DE
Paramus Endoscopy, LLC (d/b/a 1)Endoscopy Center of Bergen County 2)Surgical & Endoscopy Center of Bergen County)	NJ
Park Cities Surgery Center, LLC	TX
Park Place Investor Group, LP	TX
Parkway Recovery Care Center, LLC	NV
Parkway Surgery Center, LLC	NV
Parkwest Surgery Center, L.P.	TN
Patient Partners, LLC (d/b/a Patient Partners Surgery Center)	TN
Pearland Ambulatory Surgery Center, LP	TN
Peters Township Surgery Center, LLC	PA
Physicians Pavilion, L.P.	DE
Physicians Surgery Center at Good Samaritan, LLC (d/b/a Good Samaritan Surgery Center)	IL
Physician's Surgery Center of Chattanooga, L.L.C. (d/b/a Anesthesia Services of PSCC)	TN
Physician's Surgery Center of Knoxville, LLC	TN
Physicians Surgical Center of Ft. Worth, LLP (d/b/a 1)Baylor Surgicare at Fort Worth I 2)Baylor Surgicare at Fort Worth II 3)Physicians Surgical Center of Ft. Worth II)	TX
Providence/USP Santa Clarita GP, LLC (d/b/a Providence Summit Surgery Center)	CA
Providence/USP Surgery Centers, L.L.C.	CA
Radsource, LLC	DE
Reading Ambulatory Surgery Center, L.P. (d/b/a Reading Surgery Center)	PA
Reading Endoscopy Center, LLC	DE
Redmond Surgery Center, LLC	TN
RE Plano Med, Inc.	TX
Resurgens Surgery Center, LLC (d/b/a Resurgens Surgical Center)	GA
Richmond ASC Leasing Company, LLC	VA
River North Same Day Surgery, L.L.C. (d/b/a Sameday Surgery River North)	IL
Riverside Ambulatory Surgery Center, LLC (d/b/a 1)Riverside Surgery Center 2)UAP Riverside 3)The Endoscopy & Colonoscopy Center)	MO
Rockwall Ambulatory Surgery Center, L.L.P. (d/b/a 1)Baylor Surgicare at Rockwall 2)Rockwall Surgery Center)	TX
Rockwall/Heath Surgery Center, L.L.P. (d/b/a Baylor Surgicare at Heath)	TX
Roseville Surgery Center, L.P. (d/b/a Roseville Surgery Center)	CA
Roswell Surgery Center, L.L.C.	GA
Saint Thomas Campus Surgicare, L.P.	TN
Saint Thomas/USP Surgery Centers II, LLC	TN
Saint Thomas/USP Surgery Centers, L.L.C.	TN
Saint Thomas/USP-Baptist Plaza, L.L.C.	TN
Same Day Management, L.L.C.	IL
Same Day Surgery, LLC	IL
San Antonio Endoscopy, L.P.	TX

Attachment 15

NAME	STATE INCORPORATED
San Fernando Valley Surgery Center, LP (d/b/a Providence Holy Cross Surgery Center at Mission Hills)	CA
San Gabriel Valley Surgical Center, L.P.	CA
San Martin Surgery Center, LLC (d/b/a Durango Outpatient Surgery Center)	NV
Santa Clarita Surgery Center, L.P.	CA
Scripps Encinitas Surgery Center, LLC	CA
Scripps/USP Surgery Centers, L.L.C.	CA
Shore Outpatient Surgicenter, L.L.C.	GA
Shoreline Real Estate Partnership, LLP	TX
Shoreline Surgery Center, LLP (d/b/a CHRISTUS Spohn—Surgicare of Corpus Christi)	TX
Shrewsbury Surgery Center, LLC	NJ
Silicon Valley Outpatient Surgery Centers, LLC	CA
Siouxland Surgery Center Limited Liability Partnership (d/b/a Siouxland Surgery Center)	IA
SKV UAP Sugarland, LLC	TX
SLPA ACO, LLC	MO
South County Outpatient Endoscopy Services, L.P. (d/b/a 1)South County Outpatient Endoscopy Services 2)SCOPES)	MO
Southwest Ambulatory Surgery Center, L.L.C.	OK
Southwest Orthopedic and Spine Hospital Real Estate, LLC	DE
Southwest Orthopedic and Spine Hospital, LLC (d/b/a 1)O:A:S:I:S Hospital 2)O:A:S:I:S: Orthopedic and Spine Inpatient Surgical Hospital)	AZ
Southwestern Ambulatory Surgery Center, LLC	PA
Specialty Surgery Center of Fort Worth, L.P. (d/b/a 1)Specialty Surgery Center of Fort Worth 2)Baylor Surgicare at NE Fort Worth 3)Baylor Surgicare at Northeast Fort Worth)	TX
Specialty Surgicenters, Inc.	GA
Spinal Diagnostics and Treatment Centers, LLC	CA
SSI Holdings, inc.	GA
SSM St. Clare Surgical Center, L.L.C.	MO
St. Joseph's Outpatient Surgery Center, LLC (d/b/a St. Joseph's Recovery Care Center)	AZ
St. Joseph's Surgery Center, L.P.	CA
St. Louis Physician Alliance, LLC	MO
St. Louis Surgical Center, LC	MO
St. Mary's Ambulatory Surgery Center, LLC	VA
St. Mary's Surgical Center, LLC (d/b/a St. Mary's Surgical Center)	MO
St. Mary's/USP Surgery Centers, LLC	MO
St. Vincent Health/USP, LLC	IN
St. Vincent/USP Surgery Centers, LLC	AR
Stockton Outpatient Surgery Center, LLC (d/b/a Ambulatory Surgery Center of Stockton)	CA
Suburban Endoscopy Center, LLC (d/b/a UAP Verona Endo)	NJ
Summit View Surgery Center, LLC (d/b/a Summit View Surgery Center)	CO
Sunset Hills Ambulatory Surgery Center, L.P. (d/b/a Sunset Hills Surgery Center)	MO
Surgery Center of Atlanta, LLC	GA
Surgery Center of Canfield, LLC	OH
Surgery Center of Columbia, L.P. (d/b/a Surgery Center of Columbia)	MO
Surgery Center of Gilbert, LLC	AZ
Surgery Center of Peoria, LLC	OK
Surgery Center of Richardson Physician Partnership, L.P. (d/b/a 1)Surgery Center of Richardson 2)Baylor Surgicare at Richardson)	TX
Surgery Center of Scottsdale, LLC (d/b/a 1)Mountain View Surgery Center of Glendale 2)Mountain View Surgery Center of Gilbert 3)Mountain View Surgery Center of Phoenix)	OK
Surgery Center of Tempe Real Estate, LLC	AZ
Surgery Center of Tempe, LLC (d/b/a Physicians Surgery Center of Tempe)	OK

NAME	STATE INCORPORATED
Surgery Centers of America II, LLC	OK
Surgical Health Partners, LLC	TN
Surgical Specialists at Princeton, LLC	NJ
Surgicenter of Baltimore, LLP	MD
Surginet, Inc.	TN
Surgis Management Services, Inc.	TN
Surgis of Chico, Inc.	TN
Surgis of Phoenix, Inc.	TN
Surgis of Redding, Inc.	TN
Surgis of Victoria, Inc.	TN
Surgis, Inc.	DE
Tamarac Surgery Center LLC (d/b/a The Surgery Center of Ft. Lauderdale)	FL
TCH/USP Surgery Centers, LLC	OH
Tempe New Day Surgery Center, L.P. (d/b/a Tempe New Day Surgery Center)	TX
TENN SM, LLC (d/b/a 1)Providence Surgery Center 2)Tennessee Sports Medicine Surgery Center, LLC)	TN
Terre Haute Surgical Center, LLC (d/b/a 1)St. Vincent Surgery Center of Terre Haute 2)Anesthesia Services of Terre Haute)	IN
Teton Outpatient Services, LLC	WY
Texan Ambulatory Surgery Center, L.P. (d/b/a Texan Surgery Center)	TX
Texas Endoscopy Centers, LLC (d/b/a 1)Texas Endoscopy 2)Texas Endoscopy at Independence Medical Village)	TX
Texas Health Venture Arlington Hospital, LLC	TX
Texas Health Venture Carrollton, LLC	TX
Texas Health Venture Ennis, LLC	TX
Texas Health Venture Fort Worth, L.L.C.	TX
Texas Health Venture Granbury, LLC	TX
Texas Health Venture Keller, LLC	TX
Texas Health Venture Las Colinas, LLC	TX
Texas Health Venture Mansfield, LLC	TX
Texas Health Venture Plano Parkway, LLC	TX
Texas Health Venture Plano, LLC	TX
Texas Health Venture Plano Endo, LLC	TX
Texas Health Ventures Group L.L.C.	TX
The Ambulatory Surgical Center of St. Louis, L.P. (d/b/a The Surgical Center of St. Louis)	MO
The Center for Ambulatory Surgical Treatment, L.P.	CA
The Christ Hospital Spine Surgery Center, LLC (d/b/a 1)Mayfield Clinic Spine Surgery Center 2)The Christ Hospital Spine Surgery Center)	OH
The Physicians' Center, L.P.	TX
The Surgery Center at Williamson, LLC (d/b/a Williamson Surgery Center)	TX
THV Park Cities, LLC	TX
THVG Arlington GP, LLC	DE
THVG Bariatric GP, LLC	TX
THVG Bariatric, L.L.C.	TX
THVG Bedford GP, LLC	DE
THVG Bellaire GP, LLC	DE
THVG Denton GP, LLC	DE
THVG DeSoto GP, LLC	DE
THVG DSP GP, LLC	DE
THVG Fort Worth GP, LLC	DE
THVG Frisco GP, LLC	DE
THVG Garland GP, LLC	DE

NAME	STATE INCORPORATED
THVG Grapevine GP, LLC	DE
THVG Heritage Park, LLC	TX
THVG Irving-Coppell GP, LLC	DE
THVG Lewisville GP, LLC	DE
THVG North Garland GP, LLC	DE
THVG Park Cities/Trophy Club GP, LLC	DE
THVG Rockwall 2 GP, LLC	TX
THVG Rockwall GP, LLC	DE
THVG Valley View GP, LLC	DE
Titan Health Corporation	DE
Titan Health of Chattanooga, Inc.	CA
Titan Health of Hershey, Inc.	CA
Titan Health of Mount Laurel, LLC	CA
Titan Health of North Haven, Inc.	CA
Titan Health af Pittsburgh, Inc.	CA
Titan Health af Pleasant Hills, Inc.	CA
Titan Health of Princeton, Inc.	CA
Titan Health of Sacramento, Inc.	CA
Titan Health of Saginaw, Inc.	CA
Titan Health of Titusville, Inc.	CA
Titan Health of West Penn, Inc.	CA
Titan Health of Westminster, Inc.	CA
Titan Management Corporation	CA
Titusville Center for Surgical Excellence, LLC	DE
TMC Holding Company, LLC	TX
Toms River Surgery Center, L.L.C.	NJ
TOPS Specialty Hospital, Ltd. (d/b/a TOPS Surgical Specialty Hospital)	TX
Total Joint Center of St. Louis, LP (d/b/a Total Joint Center of St. Louis)	MO
TP Specialty Surgery Center, L.P. (d/b/a Turning Point Specialty Surgery Center)	TX
Trophy Club Medical Center, L.P. (d/b/a 1)Baylor Medical Center at Trophy Club 2)Baylor Surgicare at Trophy Club)	TX
True Medical Weight Loss, L.P.	TX
True Medical Wellness, L.P.	TX
True Results Georgia, Inc.	GA
True Results Missouri, LLC	MO
Tuscan Surgery Center at Las Colinas, LLC (d/b/a Texas Digestive Disease Center)	TX
Twin Cities Ambulatory Surgery Center, LP (d/b/a Twin Cities Surgery Center)	MO
UAP Chattanooga Pain LLC	TN
UAP Keller Endo, LLC	TX
UAP Las Colinas Endo, LLC	TX
UAP Lebanon Endo, LLC	TN
UAP Nashville Endoscopy, LLC	TN
UAP of Arizona, Inc.	AZ
UAP of California, Inc.	CA
UAP of Missouri, Inc.	MO
UAP of New Jersey, Inc.	NJ
UAP of Tennessee, Inc.	TN
UAP of Texas, Inc.	TX
UAP Sacramento, LLC	CA
UAP San Antonio Endo, LLC	TX
UAP Scopes, LLC	MO
United Anesthesia Partners, Inc.	DE

NAME	STATE INCORPORATED
United Surgery Center—Southeast, Ltd. (d/b/a United Surgery Center—Southeast)	TX
United Surgical Partners Holdings, Inc.	DE
University Surgery Center, Ltd. (d/b/a University Surgical Center)	FL
University Surgical Partners of Dallas, L.L.P.	TX
Upper Cumberland Physicians' Surgery Center, LLC	TN
USP Alexandria, Inc.	LA
USP Assurance Company	VT
USP Austin, Inc.	TX
USP Bariatric, LLC	DE
USP Beaumont, Inc.	TX
USP Bergen, Inc.	NJ
USP Bloomington, Inc.	IN
USP Bridgeton, Inc.	MO
USP Cedar Park, Inc.	TX
USP Chesterfield, Inc.	MO
USP Chicago, Inc.	IL
USP Cincinnati, Inc.	OH
USP Coast, Inc.	CA
USP Columbia, Inc.	MO
USP Corpus Christi, Inc.	TX
USP Creve Coeur, Inc.	MO
USP Denver, Inc.	CO
USP Des Peres, Inc.	MO
USP Destin, Inc.	FL
USP Domestic Holdings, Inc.	DE
USP Effingham, Inc.	IL
USP Encinitas Endoscopy, Inc.	CA
USP Fenton, Inc.	MO
USP Festus, Inc.	MO
USP Florissant, Inc.	MO
USP Fort Lauderdale, Inc.	FL
USP Fort Worth Hospital Real Estate, Inc.	TX
USP Fredericksburg, Inc.	VA
USP Frontenac, Inc.	MO
USP Gateway, Inc.	MO
USP Harbour View, Inc.	VA
USP Hazelwood, Inc.	MO
USP Houston, Inc.	TX
USP Indiana, Inc.	IN
USP International Holdings, Inc.	DE
USP Jersey City, Inc.	NJ
USP Kansas City, Inc.	MO
USP Knoxville, Inc.	TN
USP Little Rock, Inc.	AR
USP Long Island, Inc.	DE
USP Louisiana, Inc.	LA
USP Maryland, Inc.	MD
USP Mason Ridge, Inc.	MO
USP Mattis, Inc.	MO
USP Michigan, Inc.	MI
USP Midland, Inc.	TX
USP Midwest, Inc.	IL

NAME	STATE INCORPORATED
USP Mission Hills, Inc.	CA
USP Morris, Inc.	NJ
USP Mt. Vernon, Inc.	IL
USP Nevada, Inc.	NV
USP Nevada Holdings, LLC	NV
USP New Jersey, Inc.	NJ
USP Newport News, Inc.	VA
USP North Kansas City, Inc.	MO
USP North Texas, Inc.	DE
USP Northwest Arkansas, Inc.	AR
USP Office Parkway, Inc.	MO
USP Oklahoma, Inc.	OK
USP Olive, Inc.	MO
USP Orlando, Inc.	FL
USP Philadelphia, Inc.	PA
USP Phoenix, Inc.	AZ
USP Portland, Inc.	OR
USP Reading, Inc.	PA
USP Richmond II, Inc.	VA
USP Richmond, Inc.	VA
USP Sacramento, Inc.	CA
USP San Antonio, Inc.	TX
USP Securities Corporation	TN
USP Siouxland, Inc.	IA
USP Somerset, Inc.	NJ
USP St. Louis, Inc.	MO
USP St. Peters, Inc.	MO
USP Sunset Hills, Inc. (d/b/a 1)Scheduling Solutions 2)USP St. Louis CBO)	MO
USP Tennessee, Inc.	TN
USP Texas Air, L.L.C.	TX
USP Texas, L.P.	TX
USP TJ STL, Inc.	MO
USP Torrance, Inc.	CA
USP Tumersville, Inc.	NJ
USP Virginia Beach, Inc.	VA
USP Waxahachie Management, L.L.C	TX
USP Webster Groves, Inc.	MO
USP West Covina, Inc.	CA
USP Westwood, Inc.	CA
USP Winter Park, Inc.	FL
USPI Physician Strategy Group, LLC (d/b/a Physician Strategy Group)	TX
USPI San Diego, Inc.	CA
USPI Stockton, Inc.	CA
USPI Surgical Services, Inc.	DE
Utica ASC Partners, LLC (d/b/a 1)Utica Surgery Center 2)Utica Surgery and Endoscopy Center)	MI
Utica/USP Tulsa, L.L.C.	OK
Valley View Surgicare Partners, Ltd. (d/b/a 1)Baylor Surgicare at Valley View 2)Valley View Surgery Center)	TX
Verosean, Inc.	DE
Victoria Ambulatory Surgery Center, LP (d/b/a The Surgery Center)	DE
Warner Park Surgery Center, LP (d/b/a Warner Outpatient Surgery Center)	AZ

Exhibit 24.1

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that each of said attorneys-in-fact or their substitute or substitutes may lawfully do or cause to be done by virtue hereof.

/s/ Paul B. Queally
Paul B. Queally

Exhibit 24.2

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014 and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ Joel T. Allison
Joel T. Allison

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ Anthony F. Ecock
Anthony F. Ecock

Exhibit 24.4

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ John C. Garrett, M.D.
John C. Garrett, M.D.

Exhibit 24.5

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ D. Scott Mackesy
D. Scott Mackesy

Exhibit 24.6

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ James Ken Newman

James Ken Newman

Exhibit 24.7

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ Harold L. Paz, M.D., M.S.
Harold L. Paz, M.D., M.S.

Exhibit 24.8

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that the undersigned hereby constitutes and appoints Jason B. Cagle and W. Bradley Bickham, and each of them, his true and lawful attorneys-in-fact, with full power of substitution and resubstitution, for him and in his name, place and stead, to sign on his behalf, as a director or officer, or both, as the case may be, of United Surgical Partners International, Inc., a Delaware corporation (the "Corporation"), the Corporation's Annual Report on Form 10-K for the year ended December 31, 2014, and to sign any or all amendments to such Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact, and each of them with or without the others, full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he might or could do in person.

/s/ Raymond A. Ranelli
Raymond A. Ranelli

EXHIBIT 31.1

SARBANES-OXLEY SECTION 302 CERTIFICATION

I, William H. Wilcox, certify that:

1. I have reviewed this annual report on Form 10-K of United Surgical Partners International, Inc.;

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.

/s/ William H. Wilcox
William H. Wilcox
Chief Executive Officer

February 25, 2015

EXHIBIT 31.2

SARBANES-OXLEY SECTION 302 CERTIFICATION

I, Jason B. Cagle, certify that:

1. I have reviewed this annual report on Form 10-K of United Surgical Partners International, Inc.;

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.

/s/ Jason B. Cagle
Jason B. Cagle
Chief Financial Officer

February 25, 2015

EXHIBIT 32.1

SARBANES-OXLEY SECTION 906 CERTIFICATION

In connection with the Annual Report of United Surgical Partners International, Inc. (the "Company") on Form 10-K for the period ended December 31, 2014 as filed with the Securities and Exchange Commission (the "Report"), I, William H. Wilcox, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ William H. Wilcox
William H. Wilcox
Chief Executive Officer

February 25, 2015

A signed original of this written statement required by Section 906 has been provided to the Registrant and will be retained by the Registrant and furnished to the Securities and Exchange Commission or its staff upon request.

Attachment
15

EXHIBIT 32.2

SARBANES-OXLEY SECTION 906 CERTIFICATION

In connection with the Annual Report of United Surgical Partners International, Inc. (the "Company") on Form 10-K for the period ended December 31, 2014 as filed with the Securities and Exchange Commission (the "Report"), I, Jason B. Cagle, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Jason B. Cagle
Jason B. Cagle
Chief Financial Officer

February 25, 2015

A signed original of this written statement required by Section 906 has been provided to the Registrant and will be retained by the Registrant and furnished to the Securities and Exchange Commission or its staff upon request.

Attachment
15

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Form 10-K

☒ **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2016**

OR

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

Commission File Number 1-7293

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

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

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

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

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

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

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

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

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

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

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

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

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

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

As of June 30, 2016, the aggregate market value of the shares of common stock held by non-affiliates of the Registrant (treating directors, executive officers who were SEC reporting persons, and holders of 10% or more of the common stock outstanding as of that date, for this purpose, as affiliates) was approximately $1.9 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 31, 2017, there were 99,813,435 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2017 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

Attachment 15

TABLE OF CONTENTS

PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks, primarily in large urban and suburban markets in the United States. At December 31, 2016, we operated 79 hospitals, 20 short-stay surgical hospitals, over 470 outpatient centers, and nine facilities in the United Kingdom through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI joint venture"). In addition, our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other, Ambulatory Care and Conifer. Additional information about our business segments is provided below, and financial and statistical data for the segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

The healthcare industry, in general, and the acute care hospital business, in particular, are experiencing significant regulatory uncertainty based, in large part, on legislative 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 these actions on our future revenues and operations. However, we believe that our ultimate success in increasing our profitability depends in part on our success in executing the strategies discussed in detail in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. In general, these strategies are intended to address the following trends shaping the demand for healthcare services: (i) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (ii) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (iii) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (iv) consolidation continues across the entire healthcare sector through both traditional acquisition and divestiture activities, as well as joint ventures. Our ability to execute on our strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

Over the past several years, and with the aforementioned trends in mind, we have taken a number of steps to better position Tenet to compete more effectively in the ever evolving healthcare environment. We have set competitive prices for our services, made capital and other investments in our facilities and technology, increased our efforts to recruit and retain quality physicians, nurses and other healthcare personnel, and negotiated competitive contracts with managed care and other private payers. In addition, we have expanded our network of outpatient centers, and we have increased the participation of our hospitals in accountable care organizations. We have also entered into joint ventures with other healthcare providers in several of our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum. Moreover, we are continuing our strategy of selling assets in non-core markets, such as our former hospitals and related operations in Georgia and North Carolina, as well as sub-scale businesses, such as our health plans. With respect to Conifer, we have added new clients in the revenue cycle and value-based care businesses and expanded engagements with existing clients.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—At December 31, 2016, our subsidiaries operated 79 hospitals, including three academic medical centers, two children's hospitals, two specialty hospitals and one critical access hospital, serving primarily urban and suburban communities in 12 states. Our subsidiaries had sole ownership of 62 of those hospitals, 14 were owned or leased by entities that are, in turn, jointly owned by a

Tenet subsidiary and a healthcare system partner or group of physicians, and three were owned by third parties and leased by our wholly owned subsidiaries. Our Hospital Operations and other segment also included 177 outpatient centers at December 31, 2016, the majority of which are provider-based diagnostic imaging centers, freestanding urgent care centers, satellite emergency departments and provider-based ambulatory surgery centers. In addition, at December 31, 2016, our subsidiaries owned or leased and operated: a long-term acute care hospital; a number of medical office buildings, all of which were located on, or nearby, our hospital campuses; approximately 650 physician practices; accountable care networks; various health plans, which we intend to divest or wind down in 2017; and other ancillary healthcare businesses.

Our Hospital Operations and other segment generated approximately 86%, 91% and 94% of our consolidated net operating revenues for the years ended December 31, 2016, 2015 and 2014, respectively. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: (1) changes in federal and state healthcare regulations; (2) the business environment, economic conditions and demographics of local communities in which we operate; (3) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (4) seasonal cycles of illness; (5) climate and weather conditions; (6) physician recruitment, retention and attrition; (7) advances in technology and treatments that reduce length of stay; (8) local healthcare competitors; (9) managed care contract negotiations or terminations; (10) the number of patients with high-deductible health insurance plans; (11) any unfavorable publicity about us, or our joint venture partners, that affects our relationships with physicians and patients; and (12) the timing of elective procedures.

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

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

The following table lists, by state, the hospitals wholly owned, operated as part of a joint venture, or leased and operated by our wholly owned subsidiaries at December 31, 2016:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center[1]	Birmingham	607	JV
Citizens Baptist Medical Center[1]	Talladega	122	JV
Princeton Baptist Medical Center[1]	Birmingham	505	JV
Shelby Baptist Medical Center[1]	Alabaster	252	JV
Walker Baptist Medical Center[1]	Jasper	267	JV
Arizona			
Abrazo Arizona Heart Hospital[2]	Phoenix	59	Owned
Abrazo Arrowhead Campus	Glendale	217	Owned
Abrazo Central Campus	Phoenix	221	Owned
Abrazo Maryvale Campus	Phoenix	232	Owned
Abrazo Scottsdale Campus	Phoenix	136	Owned
Abrazo West Campus	Goodyear	188	Owned
Holy Cross Hospital[3], [4]	Nogales	25	JV
St. Joseph's Hospital[3]	Tucson	486	JV
St. Mary's Hospital[3]	Tucson	400	JV

Hospital	Location	Licensed Beds	Status
California			
Desert Regional Medical Center[5]	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital and Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center[6]	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center[7]	San Ramon	123	JV
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Florida Medical Center – a campus of North Shore	Lauderdale Lakes	459	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
Palm Beach Gardens Medical Center[8]	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	368	Owned
St. Mary's Medical Center	West Palm Beach	464	Owned
West Boca Medical Center	Boca Raton	195	Owned
Illinois			
Louis A. Weiss Memorial Hospital	Chicago	236	Owned
MacNeal Hospital	Berwyn	368	Owned
West Suburban Medical Center	Oak Park	234	Owned
Westlake Hospital	Melrose Park	230	Owned
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	147	Owned
MetroWest Medical Center – Leonard Morse Campus	Natick	152	Owned
Saint Vincent Hospital	Worcester	283	Owned
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	273	Owned
Harper University Hospital	Detroit	470	Owned
Huron Valley-Sinai Hospital	Commerce Township	158	Owned
Hutzel Women's Hospital	Detroit	114	Owned
Rehabilitation Institute of Michigan[2]	Detroit	69	Owned
Sinai-Grace Hospital	Detroit	404	Owned

Hospital	Location	Licensed Beds	Status
Missouri			
Des Peres Hospital	St. Louis	143	Owned
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher's Hospital for Children	Philadelphia	189	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	479	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
Baylor Scott & White Medical Center – Centennial[9], [10]	Frisco	—	JV
Baylor Scott & White Medical Center – Lake Pointe[10], [11]	Rowlett	—	JV
Baylor Scott & White Medical Center – Sunnyvale[10], [12]	Sunnyvale	—	JV
Baylor Scott & White Medical Center – White Rock[10], [13]	Dallas	—	JV
Cypress Fairbanks Medical Center	Houston	181	Owned
The Hospitals of Providence East Campus	El Paso	182	Owned
The Hospitals of Providence Memorial Campus	El Paso	480	Owned
The Hospitals of Providence Sierra Campus	El Paso	329	Owned
Houston Northwest Medical Center[14]	Houston	423	JV
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
North Central Baptist Hospital	San Antonio	429	Owned
Northeast Baptist Hospital	San Antonio	371	Owned
Park Plaza Hospital	Houston	444	Owned
Resolute Health	New Braunfels	128	Owned
St. Luke's Baptist Hospital	San Antonio	282	Owned
Valley Baptist Medical Center	Harlingen	586	Owned
Valley Baptist Medical Center – Brownsville	Brownsville	280	Owned
Total Licensed Beds		**20,354**	

(1) Operated by a limited liability company formed as part of a joint venture with Baptist Health System, Inc. ("BHS"), a not-for-profit healthcare system in Alabama; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2016, and BHS owned a 40% interest.

(2) Specialty hospital.

(3) Owned by a limited liability company formed as part of a joint venture with Dignity Health and Ascension Arizona, each of which is a not-for-profit healthcare system; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2016, Dignity Health owned a 22.5% interest and Ascension Arizona owned a 17.5% interest.

(4) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation.

(5) Lease expires in May 2027.

(6) Lease expires in July 2045.

(7) Owned by a limited liability company formed as part of a joint venture with John Muir Health ("JMH"), a not-for-profit healthcare system in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the entity at December 31, 2016, and JMH owned a 49% interest.

(8) Facility was leased at December 31, 2016; however, we exercised our purchase option under the lease in February 2016 and subsequently purchased the property in February 2017.

(9) Managed by a Tenet subsidiary and owned by a limited partnership that is owned by a limited liability partnership (the "JV LLP") formed as part of a joint venture with Baylor Scott & White Health ("BSW"), a not-for-profit healthcare system; at December 31, 2016, a Tenet subsidiary owned a 25% interest in the JV LLP, and BSW owned a 75% interest.

(10) Although we manage the operations of this hospital, we have not included its licensed beds in the table because the statistical information associated with the hospital is not presented on a consolidated basis with our other facilities.
(11) Managed by a Tenet subsidiary and owned by a limited liability company in which the JV LLP (in which we own a 25% interest, as set forth in footnote (9) above) indirectly owned a 94.67% interest at December 31, 2016. As a result, our ownership interest in this facility is approximately 23.67%.
(12) Managed by a Tenet subsidiary and operated by a limited liability company in which the JV LLP (in which we own a 25% interest, as set forth in footnote (9) above) indirectly owned a 60.18% interest at December 31, 2016. As a result, our ownership interest in this facility is approximately 15%.
(13) Managed by a Tenet subsidiary and owned by the JV LLP (in which we own a 25% interest, as set forth in footnote (9) above).
(14) Owned by a limited liability company in which a Tenet subsidiary owned an 87.8% interest at December 31, 2016 and is the managing member.

Information regarding the utilization of licensed beds and other operating statistics at December 31, 2016, 2015 and 2014 can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

At December 31, 2016, our Hospital Operations and other segment also included 66 diagnostic imaging centers, 15 satellite emergency departments, 10 ambulatory surgery centers and six urgent care centers operated as departments of our hospitals and under the same license, as well as 80 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of eight diagnostic imaging centers, seven emergency hospitals (also known as microhospitals), four ambulatory surgery centers and 61 urgent care centers, the majority of which are managed by our USPI joint venture and operated under our national MedPost brand. Over half of the outpatient centers in our Hospital Operations and other segment at December 31, 2016 were in California, Florida and Texas, the same states where we had the largest concentrations of licensed hospital beds. Strong concentrations of hospital beds and outpatient centers within market areas may help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Accountable Care Networks—We own, control or operate 18 accountable care networks – in Alabama, Arizona, California, Florida, Illinois, Michigan, Missouri, Pennsylvania and Texas – and participate in four additional accountable care networks with other healthcare providers for select markets in Arizona, California, Massachusetts and Texas. An accountable care organization ("ACO") is a network of providers and suppliers that work together to invest in infrastructure and to redesign delivery processes in an effort to achieve high quality and efficient delivery of services. Because they promote accountability and coordination of care, ACOs are intended to produce savings as a result of improved quality and operational efficiencies. ACOs that achieve quality performance standards established by the U.S. Department of Health and Human Services ("HHS") are eligible to share in a portion of the amounts saved by the Medicare program. These networks operate using a range of payment and delivery models.

Health Plans—We recently announced our intention to sell or otherwise wind down our health plan businesses by the end of 2017 because they are not a core part of our long-term strategy and are sub-scale. Our health plans remain subject to numerous federal and state statutes and regulations related to their business operations, and each health plan continues to be licensed by one or more agencies in the states in which they conduct business. In addition, insurance regulators in several of the states in which we currently operate have required us to establish cash reserves in connection with certain of our health plans.

AMBULATORY CARE SEGMENT

Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our nine European Surgical Partners Limited ("Aspen") facilities in the United Kingdom. The operations of our Ambulatory Care segment generated approximately 9% of our consolidated net operating revenues for the year ended December 31, 2016. At December 31, 2016, we had a 56.3% ownership interest in the USPI joint venture, while Welsh, Carson, Anderson & Stowe ("Welsh Carson"), a private equity firm that specializes in healthcare investments, owned approximately 41% through two subsidiaries, and Baylor University Medical Center ("Baylor") owned approximately 3%. In January 2017, the subsidiaries of Welsh Carson delivered a put notice to us for the minimum number of shares (representing a 6.25% ownership interest in our USPI joint venture) that they are required to put to us in 2017 according to our put/call agreement. We expect that the closing of the put transaction will occur in the three months ending June 30, 2017 in accordance with the terms of the put/call agreement. We are currently evaluating the additional call options available to us pursuant to the put/call agreement. Also in January 2017, Baylor exercised its option to purchase an additional 1.99%

of the total outstanding shares of the USPI joint venture from the subsidiaries of Welsh Carson. The closing of that transaction will occur following receipt of necessary regulatory approvals.

Our USPI Joint Venture's Business—Our USPI joint venture acquires and develops its facilities primarily through the formation of joint ventures with physicians and healthcare systems. Subsidiaries of the USPI joint venture hold ownership interests in the facilities directly or indirectly and operate the facilities on a day-to-day basis through management services contracts. We believe that this acquisition and development strategy and operating model will enable our USPI joint venture to continue to grow because of various industry trends we have seen emerge in recent years, namely that: (1) consumers are increasingly selecting services and providers based on cost and convenienee, as well as quality; (2) more procedures are shifting from inpatient to outpatient settings; (3) payer reimbursements have become more closely tied to performance on quality and service metrics; and (4) healthcare providers are entering into joint ventures to maximize effectiveness, reduce costs and build clinically integrated networks.

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

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

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

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

At December 31, 2016, our USPI joint venture had interests in 239 ambulatory surgery centers, 34 urgent care centers operated under the CareSpot brand, 21 imaging centers and 20 short-stay surgical hospitals in 27 states. Of these 314 facilities, 177 are jointly owned with healthcare systems. As further described in Note 1 to our Consolidated

Financial Statements, we do not consolidate the financial results of 108 of the facilities in which our USPI joint venture has an ownership interest, meaning that while we record a share of their net profit within our operating income as equity in earnings of unconsolidated affiliates, we do not include their revenues and expenses in the consolidated revenue and expense line items of our consolidated financial statements. Additional financial and other information about our Ambulatory Care operating segment can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

Aspen's Business—Aspen Healthcare's four acute care hospitals, one cancer center and four outpatient facilities offer patients in the United Kingdom a complete range of private healthcare and clinical services, including inpatient care, outpatient and minimally invasive treatment and surgery, and diagnostic imaging. As with our USPI joint venture, a number of Aspen's facilities are owned jointly with physicians and other health provider organizations.

CONIFER SEGMENT

Our Conifer subsidiary provides a number of services primarily to healthcare providers to assist them in generating improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. The operations of our Conifer segment generated approximately 5% of our consolidated net operating revenues for the year ended December 31, 2016.

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

- centralized insurance and benefit verification, financial clearance, pre-certification, registration and check-in services;
- financial counseling services, including reviews of eligibility for government healthcare programs, for both insured and uninsured patients;
- productivity and quality improvement programs, revenue cycle assessments and optimization recommendations, and accreditation preparedness services;
- coding and compliance support, billing assistance, auditing, training and data management services at every step in the revenue cycle process;
- third-party billing and collections; and
- ongoing measurement and monitoring of key revenue cycle metrics.

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

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

Management Services—Conifer also supports value-based performance through clinical integration, financial risk management and population health management, all of which assist hospitals, physicians, ACOs, health plans, self-insured employers and government agencies in improving the cost and quality of healthcare delivery, as well as patient outcomes. Conifer helps clients build clinically integrated networks that provide predictive analytics and quality measures across the care continuum. In addition, Conifer assists clients in improving both the cost and quality of care by

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

Customers—At December 31, 2016, Conifer provided one or more of the business process services described above from 20 service centers to more than 800 Tenet and non-Tenet hospital and other clients in over 40 states. In 2012, we entered into agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer. The pricing terms for the services provided by each party to the other under these contracts were based on estimated third-party pricing terms in effect at the time the agreements were signed. Prior to the expiration of these contracts in December 2018, we will undertake a new fair market value analysis with respect to the pricing of these services and use that analysis in our negotiation of renewal contracts. As a result, it is possible that the pricing under the renegotiated agreements may be different from the current agreements. In addition, Conifer has an agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 90 CHI hospitals through 2032. As further described in Note 15 to our Consolidated Financial Statements, CHI has a 23.8% ownership position in Conifer's principal operating subsidiary, Conifer Health Solutions, LLC.

For the year ended December 31, 2016, approximately 41% of Conifer's net operating revenues were attributable to its relationship with Tenet and approximately 35% were attributable to its relationship with CHI. The loss of CHI's business would have a material adverse impact on our Conifer segment, although not on Tenet as a whole. Additional financial and other information about our Conifer operating segment can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. We believe that our success in growing Conifer and increasing its profitability depends in part on our success in executing the following strategies: (1) attracting as new clients hospitals and other healthcare providers who currently handle their revenue cycle management processes internally; (2) generating new client relationships through opportunities from USPI and Tenet's acute care hospital corporate development activities; (3) expanding revenue cycle management and value-based care service offerings through organic development and small acquisitions; (4) leveraging data from tens of millions of patient interactions to capture new opportunities and service the value-based care environment to drive competitive differentiation; and (5) developing services for our Ambulatory Care segment, leveraging our USPI joint venture's capabilities. However, there can be no assurance that Conifer will be successful in generating new client relationships, particularly with respect to hospitals we or Conifer's other customers sell, as the respective buyers may not continue to use Conifer's services or, if they do, they may not do so under the same contractual terms.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2016 are set forth in the table beginning on page 2. We lease the majority of our outpatient facilities in both our Hospital Operations and other segment and our Ambulatory Care segment. These leases typically have initial terms ranging from five to 20 years, and most of the leases contain options to extend the lease periods. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own many of these medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

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

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. However, third parties may develop intellectual

property that is similar or superior to ours. We also license third-party software, other technology and certain trademarks through agreements that impose specific restrictions on our ability to use the licensed items, such as prohibiting reverse engineering and limiting the use of copies with respect to licensed software. We control access to and use of our software and other technology through a combination of internal and external controls. Although we do not believe the intellectual property we utilize infringes any intellectual property right held by a third party, we could be prevented from utilizing such property and could be subject to significant damage awards if our use is found to do so.

PHYSICIANS AND EMPLOYEES

Physicians—Our operations depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and who affiliate with us and use our facilities as an extension of their practices. Under state laws and other licensing standards, medical staffs are generally self-governing organizations subject to ultimate oversight by the facility's local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing facilities at any time. At December 31, 2016, we owned approximately 650 physician practices, and we employed (where permitted by state law) or otherwise affiliated with nearly 2,000 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals and outpatient centers. It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Moreover, our ability to recruit and employ physicians is closely regulated.

Employees—At December 31, 2016, we employed over 130,000 people (of which 23% were part-time employees) in our three business segments, as follows:

Hospital Operations and other[1]	98,500
Ambulatory Care	17,540
Conifer	15,570
Total	**131,610**

(1) Includes approximately 1,000 employees supporting the consolidated operations of our business.

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

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

Union Activity and Labor Relations—At December 31, 2016, approximately 23% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 34 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six expired contracts covering approximately 8% of our unionized employees and are negotiating renewals under extension agreements. We are also negotiating first contracts at three hospitals and one physician practice covering approximately 5% of our unionized employees where employees recently selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that

strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods.

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

COMPETITION

HEALTHCARE SERVICES

Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, competing facilities (1) may offer a broader array of services to patients and physicians than ours, (2) may have larger or more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, (4) may be more centrally located with better parking or closer proximity to public transportation or (5) may be able to negotiate more favorable reimbursement rates that they may use to strengthen their competitive position. In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies, as well as health insurers and private equity companies seeking to acquire providers, in specific geographic markets.

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

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

In addition, the competitive position of hospitals and outpatient facilities is dependent in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of the hospitals and who affiliate with and use outpatient facilities as an extension of their practices. Members of the medical staffs of our hospitals also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing facilities at any time.

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

Our strategies are designed to help our hospitals and outpatient facilities remain competitive. We believe targeted capital spending on critical growth opportunities, emphasis on higher-demand clinical service lines (including outpatient lines) and improved quality metrics at our hospitals will improve our patient volumes. Furthermore, we have significantly expanded our outpatient business, and we have increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, increased predictability and efficiency for physicians, and lower costs for payers. We have also sought to include all of our hospitals and other healthcare businesses in the related geographic area or nationally when negotiating new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks.

We have made significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of other physicians on the medical staff, the location of the hospital, and the quality of the hospital's facilities, equipment and employees. In addition, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effects of: (1) reducing costs; (2) increasing payments from Medicare and certain managed care payers for our services as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others; and (3) increasing physician and patient satisfaction, which may improve our volumes.

Moreover, in several markets, we have formed clinically integrated organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model. However, we do face competition from other healthcare systems that are implementing similar physician alignment strategies, such as employing physicians, acquiring physician practice groups, and participating in ACOs or other clinical integration models.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Our Conifer subsidiary faces competition from existing participants and new entrants to the revenue cycle management market, some of which may have significantly greater capital resources than Conifer. In addition, the internal revenue cycle management staff of hospitals and other healthcare providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions may choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, most of which focus on small components of the hospital revenue cycle, including:

- software vendors and other technology-supported revenue cycle management business process outsourcing companies;
- traditional consultants, either specialized healthcare consulting firms or healthcare divisions of large accounting firms; and
- large, non-healthcare focused business process and information technology outsourcing firms.

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

Conifer has pursued a program to attract additional clients and diversify its client base. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition has resulted and may continue to result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

HEALTHCARE REGULATION AND LICENSING

HEALTHCARE REFORM

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

As further discussed in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report, the expansion of health insurance coverage under the ACA resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as result, our revenues has historically been derived from government healthcare programs, reductions to our reimbursement under the Medicare and Medicaid programs as a result of the ACA have been partially offset by increased revenues from providing care to previously uninsured individuals.

In January 2017, some members of Congress began renewed efforts to modify, repeal or otherwise invalidate all or significant portions of the ACA. In addition, the President issued an executive order on January 20, 2017 declaring that the official policy of his administration will be to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations.

We cannot predict if or when modification or repeal of the ACA will take effect or what action, if any, Congress might take with respect to replacing the law. We are also unable to predict the impact of legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare disproportionate share hospital ("DSH") payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in federal fiscal year ("FFY") 2018) are made.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Anti-Kickback Statute—Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute") prohibit certain business practices and relationships that might affect the provision and cost of healthcare services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other

matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program. Moreover, the Affordable Care Act, which remains law at this time, amended the Anti-kickback Statute to provide that intent to violate the Anti-kickback Statute is not required; rather, intent to violate the law generally is all that is required.

Sanctions for violating the Anti-kickback Statute include criminal and civil penalties, as well as fines and mandatory exclusion from government programs, such as Medicare and Medicaid. In addition, submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act ("FCA"). Furthermore, it is a violation of the federal Civil Monetary Penalties Law to offer or transfer anything of value to Medicare or Medicaid beneficiaries that is likely to influence their decision to obtain covered goods or services from one provider or service over another. Many states have statutes similar to the federal Anti-kickback Statute, except that the state statutes usually apply to referrals for services reimbursed by all third-party payers, not just federal programs.

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

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

The Affordable Care Act also made changes to the "whole hospital" exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in existing physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital had physician ownership

and a Medicare provider agreement as of March 23, 2010 (or, for those hospitals under development at the time of the ACA's enactment, as of December 31, 2010). A physician-owned hospital that meets these requirements is still subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for hospitals with a high percentage of Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. Physician-owned hospitals are also currently subject to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements.

Implications of Fraud and Abuse Laws—At December 31, 2016, three of our hospitals in our Hospital Operations and other segment, and the majority of the facilities that operate as hospitals in our Ambulatory Care segment, are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals. Furthermore, the majority of ambulatory surgery centers in our Ambulatory Care segment, which are owned by joint ventures with physicians or healthcare systems, are subject to the Anti-kickback Statute and, in certain circumstances, may be subject to the Stark law. In addition, we have contracts with physicians and non-physician referral services providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements, such as medical director agreements. We have also provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-kickback Statute, the Stark law, billing requirements, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. For example, we cannot predict whether physicians may ultimately be restricted from holding ownership interests in hospitals or whether the exception relating to services provided by ambulatory surgery centers could be eliminated. We are continuing to enter into new financial arrangements with physicians and other providers in a manner we believe complies in all material respects with applicable anti-kickback and anti-fraud and abuse laws. However, governmental officials responsible for enforcing these laws may nevertheless assert that we are in violation of these provisions. In addition, these statutes or regulations may be interpreted and enforced by the courts in a manner that is not consistent with our interpretation. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that our USPI joint venture or its subsidiaries has violated any of these laws could give certain of our healthcare system partners a right to terminate their relationships with us; and any similar determination with respect to Conifer or any of its subsidiaries could give Conifer's customers the right to terminate their services agreements with us. Moreover, any violations by and resulting penalties or exclusions imposed upon our USPI joint venture's healthcare system partners or Conifer's customers could adversely affect their financial condition and, in turn, have a material adverse effect on our business and results of operations.

Retention of Independent Compliance Monitor—As previously disclosed, in September 2016, one of our subsidiaries, Tenet HealthSystem Medical, Inc. ("THSMI"), entered into a Non-Prosecution Agreement ("NPA") with the Criminal Division, Fraud Section, of the U.S. Department of Justice ("DOJ") and the U.S. Attorney's Office for the Northern District of Georgia (together, the "Offices"). The NPA requires, among other things, (i) THSMI and the Company to fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, and (ii) the Company to retain an independent compliance monitor to assess, oversee and monitor its compliance with the obligations under the NPA. On February 1, 2017, the Company retained two independent co-monitors (the "Monitor"), who are partners in a national law firm.

The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained). However, in the event the Offices determine, in their sole discretion, that the Company, or any of its subsidiaries or affiliates, has knowingly violated any provision of the NPA, the NPA could be extended by the Offices,

in their sole discretion, for up to one year, without prejudice to the Offices' other rights under the NPA. Conversely, in the event the Offices find, in their sole discretion, that there exists a change in circumstances sufficient to eliminate the need for a monitor, or that the other provisions of the NPA have been satisfied, the oversight of the Monitor or the NPA itself may be terminated early.

The Monitor's primary responsibility is to assess, oversee and monitor the Company's compliance with its obligations under the NPA, so as to specifically address and reduce the risk of any recurrence of violations of the Anti-kickback Statute and Stark law (collectively, "Misconduct") by any entity the Company owns, in whole or in part. In doing so, the Monitor will review and monitor the effectiveness of the Company's compliance with the Anti-kickback Statute and the Stark law, as well as respective implementing regulations, advisories and advisory opinions promulgated thereunder, and make such recommendations as the Monitor believes are necessary to comply with the NPA. With respect to all entities in which the Company or one of its affiliates owns a direct or indirect equity interest of 50% or less and does not manage or control the day-to-day operations, the Monitor's access to such entities shall be co-extensive with the Company's access or control and for the purpose of reviewing the conduct. During its term, the Monitor will review and provide recommendations for improving compliance with the Anti-kickback Statute and Stark law, as well as the design, implementation and enforcement of the Company's compliance and ethics programs for the purpose of preventing future criminal and ethical violations by the Company and its subsidiaries, including, but not limited to, violations related to the conduct giving rise to the NPA and the Criminal Information filed in connection with the NPA. For additional information regarding the duties and authorities of the Monitor, reference is made to the Company's Current Report on Form 8-K filed on October 3, 2016.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

To receive reimbursement from CMS for electronic claims, healthcare providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain healthcare information electronically. Effective October 1, 2015, CMS changed the formats used for certain electronic transactions and began requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. Although use of the ICD-10 code sets required significant modifications to our payment systems and processes, the costs of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial condition, results of operations or revenues. Furthermore, our electronic data transmissions are compliant with current HHS standards for additional electronic transactions and with HHS' operating rules to promote uniformity in the implementation of each standardized electronic transaction.

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

In 2009, HIPAA was amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act to impose certain of the HIPAA privacy and security requirements directly upon business associates of covered entities and significantly increase the monetary penalties for violations of HIPAA. Regulations that took effect in late 2009 also require business associates such as Conifer to notify covered entities, who in turn must notify affected

individuals and government authorities, of data security breaches involving unsecured PHI. Since the passage of the HITECH Act, enforcement of HIPAA violations has increased. A knowing breach of the HIPAA privacy and security requirements made applicable to business associates by the HITECH Act could expose Conifer to criminal liability (as well as contractual liability to the associated covered entity), and a breach of safeguards and processes that is not due to reasonable cause or involves willful neglect could expose Conifer to significant civil penalties and the possibility of civil litigation under HIPAA and applicable state law.

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

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the healthcare industry. The operational mission of the Office of Inspector General ("OIG") of HHS is to protect the integrity of the Medicare and Medicaid programs and the well-being of program beneficiaries by: detecting and preventing waste, fraud and abuse; identifying opportunities to improve program economy, efficiency and effectiveness; and holding accountable those who do not meet program requirements or who violate federal laws. The OIG carries out its mission by conducting audits, evaluations and investigations and, when appropriate, imposing civil monetary penalties, assessments and administrative sanctions. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with the laws, rules and regulations affecting the healthcare industry, these policies and procedures may not be effective.

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

As previously disclosed, in September 2016, the Company and certain of its subsidiaries, including THSMI, Atlanta Medical Center, Inc. ("AMCI") and North Fulton Medical Center, Inc. ("NFMCI"), executed agreements with the DOJ and others to resolve a civil qui tam action and criminal investigation. In accordance with the terms of the resolution agreements, AMCI and NFMCI pled guilty before the U.S. District Court for the Northern District of Georgia to conspiring to violate the Anti-kickback Statute and defraud the United States. In addition, in accordance with the resolution agreements, AMCI and NFMCI paid forfeiture money judgments in the total amount of approximately $146 million to the United States, and the Company paid approximately $372 million to resolve the civil qui tam litigation. If we are alleged or found to have violated the terms of the NPA described above or federal healthcare laws, rules or regulations in the future, our business, financial condition, results of operations or cash flows could be materially adversely affected. We may be required to defend qui tam actions in the future, and we are unable to predict the impact of such actions on our business, financial condition, results of operations or cash flows.

HEALTHCARE FACILITY LICENSING REQUIREMENTS

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

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

There has been increased scrutiny from outside auditors, government enforcement agencies and others, as well as an increased risk of government investigations and qui tam lawsuits, related to hospitals' Medicare observation rates and inpatient admission decisions. The term "Medicare observation rate" is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In addition, CMS has established a concept referred to as the "two-midnight rule" to guide practitioners admitting patients and contractors on when it is appropriate to admit individuals as hospital inpatients. Under the two-midnight rule, full implementation and enforcement of which began on January 1, 2016, CMS has indicated that a Medicare patient should generally be admitted on an inpatient basis only when there is a reasonable expectation that the patient's care will cross two midnights; if not, the patient generally should be treated as an outpatient, unless an exception applies. In our affiliated hospitals, we conduct reviews of Medicare inpatient stays of less than two midnights to determine whether a patient qualifies for inpatient admission. We do not believe enforcement of the two-midnight rule will have a material impact on inpatient admission rates at our hospitals.

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

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates or determinations of need, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for capital

expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Our subsidiaries operate hospitals in eight states that require a form of state approval under certificate of need programs applicable to those hospitals. Approximately 49% of our licensed hospital beds are located in these states (namely, Alabama, Florida, Illinois, Massachusetts, Michigan, Missouri, South Carolina and Tennessee). The certificate of need programs in most of these states, along with several others, also apply to ambulatory surgery centers.

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

ENVIRONMENTAL MATTERS

Our healthcare operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with statutes and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows. There were no material capital expenditures for environmental matters in the year ended December 31, 2016.

ANTITRUST LAWS

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

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

We believe we are in compliance with federal and state antitrust laws, but there can be no assurance that a review of our practices by courts or regulatory authorities would not result in a determination that could adversely affect our operations.

REGULATIONS AFFECTING CONIFER'S OPERATIONS

As described below, Conifer and certain of its subsidiaries are subject to statutes and regulations regarding their consumer finance, debt collection and credit reporting activities.

DEBT COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act ("FDCPA") regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC ("SOS"), are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt. In addition, the FDCPA contains various notice and disclosure requirements and imposes certain limitations on lawsuits to collect debts against consumers. Debt collection activities are also regulated at the state level. Most states have laws regulating debt collection activities in ways that are similar to, and in some cases more stringent than, the FDCPA.

Many states also regulate the collection practices of creditors who collect their own debt. These state regulations are often the same or similar to state regulations applicable to third-party collectors. Certain of the accounts receivable Conifer manages for its clients are subject to these state regulations.

In certain situations, the activities of SOS are also subject to the Fair Credit Reporting Act ("FCRA"). The FCRA regulates the collection, dissemination and use of consumer information, including consumer credit information. State credit reporting laws, to the extent they are not preempted by the FCRA, may also apply to SOS.

The federal Fair and Accurate Credit Transaction Act ("FACTA") requires Conifer to adopt (1) written guidance and procedures for detecting, preventing and responding appropriately to mitigate identity theft, and (2) coworker policies and procedures (including training) that address the importance of protecting non-public personal information and aid Conifer in detecting and responding to suspicious activity, including suspicious activity that may suggest a possible identity theft red flag, as appropriate.

Conifer and its subsidiaries are also subject to regulation by the Federal Trade Commission and the U.S. Consumer Financial Protection Bureau ("CFPB"). Both the FTC and the CFPB have the authority to investigate consumer complaints relating to a variety of consumer protection laws, including the FDCPA, FCRA and FACTA, and to initiate enforcement actions, including actions to seek restitution and monetary penalties from, or to require changes in business practices of, regulated entities. State officials typically have authority to enforce corresponding state laws. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

PAYMENT ACTIVITY RISKS

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

COMPLIANCE AND ETHICS

General—Our ethics and compliance department maintains our multi-faceted, values-based ethics and compliance program, which is designed to (1) help staff in our corporate, USPI joint venture and Conifer offices, hospitals, outpatient centers, health plan offices and physician practices meet or exceed applicable standards established by federal and state statutes and regulations, as well as industry practice, and (2) monitor and raise awareness of ethical

issues among employees and others, and stress the importance of understanding and complying with our *Standards of Conduct*. The ethics and compliance department operates with independence — it has its own operating budget; it has the authority to hire outside counsel, access any Tenet document and interview any of our personnel; and our chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

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

- support and maintain our present and future responsibilities with regard to participation in federal healthcare programs; and

- further our goals of operating an organization that (1) fosters and maintains the highest ethical standards among all employees, officers and directors, physicians practicing at Tenet facilities and contractors that furnish healthcare items or services, (2) values compliance with all state and federal statutes and regulations as a foundation of its corporate philosophy, and (3) aligns its behaviors and decisions with Tenet's core values of quality, integrity, service, innovation and transparency.

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

Standards of Conduct—All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Standards of Conduct* to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and many of our contractors are also required to abide by our *Standards of Conduct*. The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable statutes and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

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

Non-Prosecution Agreement—As previously disclosed, in September 2016, our THSMI subsidiary entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia. The NPA requires, among other things, that we and THSMI (i) fully cooperate with the

Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, (ii) retain an independent compliance monitor to assess, oversee and monitor our compliance with the obligations under the NPA, (iii) promptly report any evidence or allegations of actual or potential violations of the Anti-kickback Statute, (iv) maintain our compliance and ethics program throughout our operations, including those of our subsidiaries, affiliates, agents and joint ventures (to the extent that we manage or control or THSMI manages or controls such joint ventures), and (v) notify the DOJ and undertake certain other obligations specified in the NPA relative to, among other things, any sale, merger or transfer of all or substantially all of our and THSMI's respective business operations or the business operations of our or its subsidiaries or affiliates, including an obligation to include in any contract for sale, merger, transfer or other change in corporate form a provision binding the purchaser to retain the commitment of us or THSMI, or any successor-in-interest thereto, to comply with the NPA obligations except as may otherwise be agreed by the parties to the NPA in connection with a particular transaction. The powers, duties and responsibilities of the independent compliance monitor are broadly defined.

The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained), but it may be extended or terminated early as described herein and in the NPA. If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal health care programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Availability of Documents—The full text of our *Quality, Compliance and Ethics Program Charter*, our *Standards of Conduct*, and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the "Ethics and Compliance" caption in the "About" section. A copy of our *Standards of Conduct* is also available upon written request to our corporate secretary. Information about how to contact our corporate secretary is set forth under "Company Information" below. Amendments to the *Standards of Conduct* and any grant of a waiver from a provision of the *Standards of Conduct* requiring disclosure under applicable Securities and Exchange Commission ("SEC") rules will be disclosed at the same location as the *Standards of Conduct* on our website. A copy of the NPA is attached as an exhibit to our Current Report on Form 8-K filed with the SEC on October 3, 2016.

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, 2016 through March 31, 2017, we have coverage totaling $600 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million each for floods and earthquakes and a per-occurrence sub-limit of $200 million for windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and windstorms, the total $600 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for floods, California earthquakes and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Other covered losses, including fires and other perils, have a minimum deductible of $1 million.

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

Claims in excess of our self-insurance retentions are insured with commercial insurance companies. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete

or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital.

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

COMPANY INFORMATION

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

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

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

EXECUTIVE OFFICERS

Information about our executive officers, as of February 27, 2017, is as follows:

Name	Position	Age
Trevor Fetter	Chairman, President and Chief Executive Officer	57
Daniel J. Cancelmi	Chief Financial Officer	54
Keith B. Pitts	Vice Chairman	59
J. Eric Evans	President of Hospital Operations	39
Audrey T. Andrews	Senior Vice President and General Counsel	50

Mr. Fetter was named Tenet's president in November 2002; he was appointed chief executive officer in September 2003 and chairman in May 2015. From March 2000 to November 2002, Mr. Fetter was chairman and chief executive officer of Broadlane, Inc. From October 1995 to February 2000, he served in several senior management positions at Tenet, including chief financial officer. Mr. Fetter began his career with Merrill Lynch Capital Markets, where he concentrated on corporate finance and advisory services for the entertainment and healthcare industries. In 1988, he joined Metro-Goldwyn-Mayer, Inc., where he had a broad range of corporate and operating responsibilities, rising to executive vice president and chief financial officer. Mr. Fetter holds a bachelor's degree in economics from Stanford University and an M.B.A. from Harvard Business School. He is a member of the board of directors of one other public company, The Hartford Financial Services Group, Inc. Mr. Fetter also serves on the board of directors of the Federation of American Hospitals, the board of Dean's Advisors of the Harvard Business School, the Smithsonian National board and the Dallas Citizens Council board.

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

Duquesne University in Pittsburgh. He is also a member of the American Institute of Certified Public Accountants and the Florida and Pennsylvania Institutes of Certified Public Accountants.

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

Mr. Evans was appointed Tenet's president of hospital operations in March 2016. He previously served as chief executive officer of our Texas Region from April 2015 and as market chief executive officer of The Hospitals of Providence (formerly known as the Sierra Providence Health Network) in El Paso from September 2012. Mr. Evans was the chief executive officer of the Dallas-area Lake Pointe Health Network from September 2010, where he previously held the positions of chief operating officer and director of business development after he joined Tenet in August 2004 as part of our MBA Leadership Development Program. He also served as vice president in Tenet's executive office and chief of staff from June 2009 to September 2010. Earlier in his career, Mr. Evans was an industrial engineer and a material flow coordinator at Saturn Corporation, a former subsidiary of General Motors Co. He holds a bachelor's degree in industrial management from Purdue University and an M.B.A. from Harvard Business School. He is also a fellow in the American College of Healthcare Executives. Beginning in 2014, Mr. Evans served a three-year term as a member of the board of directors of the El Paso Branch of the Federal Reserve Bank of Dallas, for which he acted as chair in 2016.

Ms. Andrews was appointed senior vice president and general counsel in January 2013. From July 2008 until that appointment, she served as senior vice president and chief compliance officer and, prior to that, served as vice president and chief compliance officer from November 2006. She joined Tenet in 1998 as hospital operations counsel. Ms. Andrews holds a J.D. and a bachelor's degree in government, both from the University of Texas at Austin. She is a member of the American and Texas Bar Associations and the American Health Lawyers Association.

FORWARD-LOOKING STATEMENTS

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

- The timing and impact on our business of the repeal or significant modification of the Affordable Care Act, the enactment of a replacement omnibus healthcare law, if any, and the enactment of, or changes in, other statutes and regulations affecting the healthcare industry generally;
- The effect that adverse economic conditions have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things;
- Adverse regulatory developments, government investigations or litigation;

- Adverse developments with respect to our ability to comply with the terms of the Non-Prosecution Agreement;
- Our ability to enter into managed care provider arrangements on acceptable terms, including our ability to mitigate the impact of national managed care contracts that expire and are not replaced;
- Cuts to Medicare and Medicaid payment rates or changes in reimbursement practices;
- Competition;
- Increases in wages and our ability to hire and retain qualified personnel, especially healthcare professionals;
- The impact of our significant indebtedness; the availability and terms of capital to fund the operation and expansion of our business; and our ability to comply with our debt covenants and, over time, reduce leverage;
- Our ability to continue to expand and realize earnings contributions from our Ambulatory Care and Conifer segments;
- Our ability to achieve operating and financial targets, attain expected levels of patient volumes, and identify and execute on measures designed to save or control costs or streamline operations;
- Our success in divesting sub-scale businesses, such as our health plans, and completing other corporate development transactions;
- Increases in the amount and risk of collectability of uninsured accounts and deductibles and copays for insured accounts;
- Changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under managed care agreements;
- The timing and impact of potential changes in federal tax policies, and the outcome of pending and any future tax audits, disputes and litigation associated with our tax positions; and
- Other factors and risks referenced in this report and our other public filings.

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

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

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties – many of which are beyond our control – that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in this report were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment.

We cannot predict the timing or outcome of Congress' plan to significantly modify or repeal the Affordable Care Act or what action, if any, legislators may take to replace the law, nor are we able to predict the ultimate effect that such actions may have on our business, financial condition, results of operations or cash flows.

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as result, our revenues has historically been derived from government healthcare programs, reductions to our reimbursement under the Medicare and Medicaid programs as a result of the ACA have been partially offset by increased revenues from providing care to previously uninsured individuals. In January 2017, some members of Congress began renewed efforts to modify, repeal or otherwise invalidate all or significant portions of the ACA. In addition, the President issued an executive order on January 20, 2017 declaring that the official policy of his administration will be to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations.

We cannot predict if or when modification or repeal of the ACA will take effect or what action, if any, Congress might take with respect to replacing the law. We are also unable to predict the impact of legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in FFY 2018) are made.

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

We currently have thousands of managed care contracts with various HMOs and PPOs. The amount of our managed care net patient revenues during the year ended December 31, 2016 was $11.2 billion, which represented approximately 62% of our total net patient revenues before provision for doubtful accounts. Approximately 61% of our managed care net patient revenues for the year ended December 31, 2016 was derived from our top ten managed care payers. In the year ended December 31, 2016, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 77% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. In addition, at December 31, 2016, approximately 66% of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

Our ability to negotiate favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Furthermore, we may experience a short- or long-term adverse effect on our net operating revenues if we cannot replace or otherwise mitigate the impact of expired contracts with national payers. A managed care contract we had with a national payer expired on September 30, 2016; as a result, our hospitals and other healthcare facilities, as well as our employed physicians, became out-of-network providers with respect to that payer's members. The contract represented approximately 2.9% of our net

operating revenues before provision for doubtful accounts for the period subsequent to the sale of our Georgia hospitals on March 31, 2016 to the contract expiration on September 30, 2016.

In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. The trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on competitive terms. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services or any significant difficulties in collecting receivables from managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from private payers could be exacerbated if we are not able to manage our operating costs effectively.

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

For the year ended December 31, 2016, approximately 21% of our net patient revenues before provision for doubtful accounts were related to the Medicare program, and approximately 8% of our net patient revenues before provision for doubtful accounts were related to various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from government programs could be exacerbated if we are not able to manage our operating costs effectively.

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

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

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

Value-based purchasing and alternative payment model initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities, and may negatively impact our revenues if we are unable to meet expected quality standards. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition,

hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions ("HACs"), unless the conditions were present at admission. Beginning in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year receive reduced Medicare reimbursements. Moreover, the ACA prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

The ACA also created the CMS Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries. In 2015, the Secretary of HHS announced a goal of tying 30% of traditional Medicare payments to quality or value through alternative payment models or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the mandatory bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria. In 2015, CMS finalized a five-year bundled payment model, called the Comprehensive Care for Joint Replacement ("CJR") model, which includes hip and knee replacements, as well as other major leg procedures. In 2016, CMS finalized additional mandatory bundled payment models, which are scheduled to begin on July 1, 2017, for Acute Myocardial Infarction ("AMI"), Coronary Artery Bypass Graft ("CABG") and Surgical Hip/Femur Fracture Treatment ("SHFFT"). Twenty of our hospitals currently participate in the CJR model and, effective July 1, 2017, certain of our hospitals are expected to be required to participate in the AMI, CABG and SHFFT models. We cannot predict what effect significant modification or repeal of the ACA as described above will have on the established payment models or the Secretary of HHS' authority to develop new payment models, nor can we predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

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

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

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

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

In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies, as well as health insurers and private equity companies seeking to acquire providers, in specific geographic

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

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

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

Furthermore, healthcare, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local healthcare regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively affecting healthcare providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We are also required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

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

In September 2016, one of our subsidiaries, Tenet HealthSystem Medical, Inc., entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia. The NPA requires, among other things, that we and THSMI (i) fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, (ii) retain an independent compliance monitor to assess, oversee and monitor our compliance with the obligations under the NPA, (iii) promptly report any evidence or allegations of actual or potential violations of the Anti-kickback Statute, (iv) maintain our compliance and ethics program throughout our operations, including those of our subsidiaries, affiliates, agents and joint ventures (to the extent that we manage or control or THSMI manages or controls such joint ventures), and (v) notify the DOJ and undertake certain other obligations specified in the NPA relative to, among other things, any sale, merger or transfer of all or substantially all of our and THSMI's respective business operations or the business operations of our or its subsidiaries or affiliates, including an obligation to include in any contract for sale, merger, transfer or other change in corporate form a provision binding the purchaser to retain the commitment of us or THSMI, or any successor-in-interest thereto, to comply with the NPA obligations except as may otherwise be agreed by the parties to the NPA in connection with a particular transaction. The powers, duties and responsibilities of the independent compliance monitor are broadly defined.

The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained), but it may be extended or terminated early as described herein and in the NPA. If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal health care programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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

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

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

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

We expect to encounter increased competition from health insurers and private equity companies seeking to acquire providers in the markets where we operate physician practices and, where permitted by law, employ physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Furthermore, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. All arrangements with physicians must also be fair market value and commercially reasonable. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

Our USPI joint venture and our hospital-based joint ventures depend on existing relationships with key healthcare system partners. If we are not able to maintain historical relationships with these healthcare systems, or enter into new relationships, we may be unable to implement our business strategies successfully.

Our USPI joint venture and our hospital-based joint ventures depend in part on the efforts, reputations and success of healthcare system partners and the strength of our relationships with those healthcare systems. Our joint ventures could be adversely affected by any damage to those healthcare systems' reputations or to our relationships with them. In addition, damage to our business reputation could negatively impact the willingness of healthcare systems to enter into relationships with us or our USPI joint venture. Moreover, in many cases, our joint venture agreements are structured to comply with current revenue rulings published by the Internal Revenue Service ("IRS"), as well as case law, relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with healthcare system partners. If we are unable to maintain existing arrangements on favorable terms or enter into relationships with additional healthcare system partners, we may be unable to implement our business strategies for our joint ventures successfully.

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

The operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, including nurses, therapists, pharmacists and lab technicians, as well as our employed physicians. We compete with other healthcare providers in recruiting and retaining employees, and, like others in the healthcare industry, we continue to experience a shortage of critical-care nurses in certain disciplines and geographic areas. As a result, from time to time, we may be required to enhance wages and benefits to recruit and retain experienced employees, make greater investments in education and training for newly licensed medical support personnel, or hire more expensive temporary or contract employees. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Increased labor union activity is another factor that could adversely affect our labor costs. At December 31, 2016, approximately 23% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 34 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six expired contracts covering approximately 8% of our unionized employees and are negotiating renewals under extension agreements. We are also negotiating first contracts at three hospitals and one physician practice covering approximately 5% of our unionized employees where employees recently selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods; to the extent a greater portion of our employee base unionizes, it is possible our labor costs could increase materially.

Conifer's future success also depends in part on our ability to attract, hire, integrate and retain key personnel. Competition for the caliber and number of employees we require at Conifer is intense. We may face difficulty identifying and hiring qualified personnel at compensation levels consistent with our existing compensation and salary structure. In addition, we invest significant time and expense in training Conifer's employees, which increases their value to competitors who may seek to recruit them. If we fail to retain our Conifer employees, we could incur significant expenses in hiring, integrating and training their replacements, and the quality of Conifer's services and its ability to serve its customers could diminish, resulting in a material adverse effect on that segment of our business.

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

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

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

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. However, there can be no assurance that Conifer will be successful in generating new client relationships, including with respect to hospitals we or Conifer's other customers sell, as the respective buyers may not continue to use Conifer's services or, if they do, they may not do so under the same contractual terms. The market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market (including software vendors and other technology-supported revenue cycle management outsourcing companies, traditional consultants and information technology outsourcing firms), as well as from the staffs of hospitals and other healthcare providers who handle these processes internally. In addition, electronic medical record software vendors may expand into services offerings that compete with Conifer. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Moreover, existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition has resulted and may continue to result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

The failure to comply with consumer protection laws could subject Conifer and its subsidiaries to fines and other liabilities, as well as harm Conifer's business and reputation.

Conifer and its subsidiaries are subject to numerous federal, state and local consumer protection laws governing such topics as privacy, finance, debt collection and credit reporting. Regulations governing debt collection are subject to changing interpretations that may be inconsistent among different jurisdictions. In addition, a regulatory determination made by, or a settlement or consent decree entered into with, one regulatory agency, such as the Consumer Financial Protection Bureau, may not be binding upon, or preclude, investigations or regulatory actions by state or local agencies. Conifer's failure to comply with consumer financial, debt collection and credit reporting requirements could result in, among other things, the issuance of cease and desist orders (which can include orders for restitution or rescission of contracts, as well as other kinds of affirmative relief), the imposition of fines or refunds, and other civil and criminal penalties, some of which could be significant in the case of knowing or reckless violations. In addition, Conifer's failure to comply with the statutes and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its customers, give customers the right to terminate Conifer's services agreements with them or give rise to contractual liabilities, among other things, any of which could have an adverse effect on Conifer's business. Furthermore, if Conifer or its subsidiaries become subject to fines or other penalties, it could harm Conifer's reputation, thereby making it more difficult for Conifer to retain existing customers or attract new customers.

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

As a provider of healthcare services, information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive and confidential data, including

protected health information, personally identifiable information, and our proprietary and confidential business performance data. We utilize electronic health records and other health information technology, along with additional technology systems, in connection with our operations, including for, among other things, billing and supply chain and labor management. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the security and availability of the data we process, transmit and store, our information technology and infrastructure have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. While we are not aware of having experienced a material breach of cybersecurity, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we may be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, or invest in new technology designed to mitigate security risks. Third parties to whom we outsource certain of our functions, or with whom our systems interface, are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting one of our third-party service providers or partners could harm our business even if we do not control the service that is attacked. Further, successful cyber-attacks at other healthcare services companies, whether or not we are impacted, could lead to a general loss of customer confidence in our industry that could negatively affect us, including harming the market perception of the effectiveness of our security measures or of the healthcare industry in general, which could result in reduced use of our services. Though we have insurance against some cyber-risks and attacks, it may not be sufficient to offset the impact of a material loss event.

Furthermore, our networks and technology systems are subject to disruption due to events such as a major earthquake, fire, hurricane, telecommunications failure, terrorist attack or other catastrophic event. Any such breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact our ability to conduct normal business operations (including the collection of revenues), and could result in potential liability under privacy, security, consumer protection or other applicable laws, regulatory penalties, negative publicity and damage to our reputation, any of which could have a material adverse effect on our business, financial position, results of operations or cash flows.

We cannot provide any assurances that our corporate development activities will achieve their business goals or the cost and service synergies we expect.

We have completed, or have announced plans to complete, a number of acquisitions, divestitures, joint ventures and strategic alliances in recent years as part of our business strategy, and we expect to enter into similar transactions in the future. We cannot provide any assurances that these transactions will achieve their business goals or the cost and service synergies we expect. In particular, our USPI joint venture represents an increased strategic focus on ambulatory and short-stay surgical facilities, as well as related imaging services businesses, and we cannot provide any assurances that this strategy will be successful. Furthermore, with respect to acquisitions, we may not be able to identify suitable candidates, consummate transactions on terms that are favorable to us, or achieve expected returns, synergies or other benefits in a timely manner or at all. With respect to proposed divestitures of assets or businesses, we may encounter difficulties in finding acquirers or alternative exit strategies on terms that are favorable to us, which could delay the receipt of anticipated proceeds necessary for us to complete our planned strategic objectives. In addition, our divestiture activities have required, and may in the future require, us to retain significant pre-closing liabilities, recognize impairment charges or agree to contractual restrictions that limit our ability to reenter the applicable market, which may be material.

Companies or operations acquired or joint ventures created may not be profitable or may not achieve the profitability that justifies the investments made. Furthermore, the nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our results could be adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our results could be

adversely affected. In addition, our relationships with not-for-profit healthcare systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current IRS revenue rulings, as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit healthcare systems and related joint venture arrangements.

Our corporate development activities may present financial and operational risks, including diversion of management attention from existing core businesses and the integration or separation of personnel and financial and other systems. Future acquisitions could also result in potentially dilutive issuances of equity securities, the incurrence of additional debt, contingent liabilities and amortization expenses related to certain intangible assets, and increased operating expenses, any of which could adversely affect our results of operations and financial condition.

Our existing joint ventures may limit our flexibility with respect to such jointly owned investments and could, thereby, have a material adverse effect on our business, results of operations and financial condition, as well as our ability to sell the underlying assets or ownership interests in the joint ventures.

We have invested in a number of joint ventures with other entities when circumstances warranted the use of these structures, and we may form additional joint ventures in the future. Our participation in joint ventures is subject to the risks that:

- We could experience an impasse on certain decisions because we do not have sole decision-making authority, which could require us to expend additional resources on resolving such impasses or potential disputes.

- We may not be able to maintain good relationships with our joint venture partners (including healthcare systems), which could limit our future growth potential and could have an adverse effect our business strategies.

- Our joint venture partners could have investment or operational goals that are not consistent with our corporate-wide objectives, including the timing, terms and strategies for investments or future growth opportunities.

- Our joint venture partners might become bankrupt, fail to fund their share of required capital contributions or fail to fulfill their other obligations as joint venture partners, which may require us to infuse our own capital into any such venture on behalf of the related joint venture partner or partners despite other competing uses for such capital.

- Many of our existing joint ventures require that one of our wholly owned affiliates provide a working capital line of credit to the joint venture, which could require us to allocate substantial financial resources to the joint venture potentially impacting our ability to fund our other short-term obligations.

- Some of our existing joint ventures require mandatory capital expenditures for the benefit of the applicable joint venture, which could limit our ability to expend funds on other corporate opportunities.

- Our joint venture partners may have exit rights that would require us to purchase their interests upon the occurrence of certain events, which could impact our financial condition by requiring us to incur additional indebtedness in order to complete such transactions or, alternatively, in some cases we may have the option to issue shares of our common stock to our joint venture partners to satisfy such obligations, which would dilute the ownership of our existing stockholders.

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

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

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

The put/call arrangements set forth in the Put/Call Agreement (as defined below) will require us to utilize our cash flow or incur additional indebtedness to satisfy the payment obligations in respect of such arrangements.

In June 2015, we entered into a Contribution and Purchase Agreement (the "Contribution and Purchase Agreement") with USPI Group Holdings, Inc. ("USPI Holdings"), Ulysses JV Holding I L.P. ("Ulysses Holding I"), Ulysses JV Holding II L.P. ("Ulysses Holding II" and, together with Ulysses Holding I, the "USPI LPs"), and the newly formed USPI Holding Company, Inc., our USPI joint venture. USPI Holdings is the parent company of United Surgical Partners International, Inc. ("USPI"). Pursuant to the terms of the Contribution and Purchase Agreement, at the closing, the USPI LPs collectively sold and contributed 100% of the equity interests of USPI Holdings to the USPI joint venture in exchange for certain shares of common stock of the USPI joint venture (the "USPI Contribution"), and we sold and contributed certain of our equity interests and other assets that comprised a portion of our ambulatory surgery center and imaging center business to the USPI joint venture (the "Tenet Contribution" and, together with the USPI Contribution, the "Contributions").We also purchased certain shares of the USPI joint venture (the "Purchase" and, together with the Contributions, the "Contribution and Purchase Transactions") from the USPI LPs such that, after giving effect to the Contribution and Purchase Transactions, we owned 50.1% and the USPI LPs, in the aggregate, owned 49.9% of the fully diluted equity interests of the USPI joint venture.

In connection with the Contribution and Purchase Agreement, we, the USPI LPs and the USPI joint venture entered into a stockholders agreement pursuant to which we and the USPI LPs agreed to certain rights and obligations with respect to the governance of the USPI joint venture. In addition, we entered into a put/call agreement (the "Put/Call Agreement") that contains put and call options with respect to the equity interests in the USPI joint venture held by the USPI LPs. Each year starting in 2016, the USPI LPs must put to us at least 12.5%, and may put up to 25%, of the USPI joint venture shares held by them immediately after the closing of the Contribution and Purchase Agreement. In each year that the USPI LPs are to deliver a put and do not put the full 25% of USPI joint venture shares allowable, we may call the difference between the number of USPI joint venture shares the USPI LPs put and the maximum number of USPI joint venture shares the USPI LPs could have put that year. In addition, the Put/Call Agreement contains certain other call options pursuant to which we will have the ability to acquire all of the ownership interests held by the USPI LPs between 2018 and 2020 (at which point we would own approximately 95% of the USPI joint venture shares). In the event of a put by the USPI LPs, we will have the ability to choose whether to settle the purchase price in cash or shares of our common stock and, in the event of a call by us, the USPI LPs will have the ability to choose whether to settle the purchase price in cash or shares of our common stock.

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

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

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

We believe broad economic factors – including high unemployment rates in some of the markets our facilities serve and instability in consumer spending – have affected our volumes and our ability to collect outstanding receivables. The United States economy remains unpredictable. If industry trends (including reductions in commercial managed care enrollment and patient decisions to postpone or cancel elective and non-emergency healthcare procedures) or general economic conditions worsen, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Furthermore, the availability of liquidity and credit to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, to access those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions, and our ability to refinance existing debt. An economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under our credit facilities, causing them to fail to meet their obligations to us.

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

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

Our level of indebtedness could, among other things, adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, and prevent us from meeting our obligations under the agreements relating to our indebtedness.

At December 31, 2016, we had approximately $15.1 billion of total long-term debt, as well as approximately $110 million in standby letters of credit outstanding in the aggregate, under our senior secured revolving credit facility (as amended, "Credit Agreement") and our letter of credit facility agreement (as amended, "LC Facility"). Our Credit Agreement is collateralized by patient accounts receivable of substantially all of our domestic wholly owned acute care and specialty hospitals, and our LC Facility is guaranteed and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. From time to time, we expect to engage in additional capital market, bank credit and other financing activities, depending on our needs and financing alternatives available at that time.

The interest expense associated with our indebtedness offsets a substantial portion of our operating income. During 2016, our interest expense was $979 million and represented approximately 80% of our $1.22 billion of operating income. As a result, relatively small percentage changes in our operating income can result in a relatively large percentage change in our net income and earnings per share, both positively and negatively. In addition:

- Our substantial indebtedness may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt.

- We may be more vulnerable in the event of a deterioration in our business, in the healthcare industry or in the economy generally, or if federal or state governments substantially limit or reduce reimbursement under the Medicare or Medicaid programs.

- Our debt service obligations reduce the amount of funds available for our operations, capital expenditures and corporate development activities, and may make it more difficult for us to satisfy our financial obligations.

- Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.

- Some of our borrowings accrue interest at variable rates, exposing us to the risk of increased interest rates.

- Our significant indebtedness may result in the market value of our stock being more volatile, potentially resulting in larger investment gains or losses for our shareholders, than the market value of the common stock of other companies that have a relatively smaller amount of indebtedness.

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

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

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

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

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

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

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

- incur, assume or guarantee additional indebtedness;

- incur liens;

- make certain investments;

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

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

In addition, so long as any obligation or commitment is outstanding under our Credit Agreement and LC Facility, the terms of such facilities require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. Our ability to meet these restrictive covenants and financial ratio may be affected by events beyond our control, and we cannot assure you that we will meet those tests. These restrictions could limit our ability to obtain future financing, make acquisitions or needed capital expenditures, withstand economic downturns in our business or the economy in general, conduct operations or otherwise take advantage of business opportunities that may arise. In addition, a breach of any of these covenants could cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

Despite current indebtedness levels, we may be able to incur substantially more debt. This could further exacerbate the risks described above.

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our Credit Agreement, LC Facility and the indentures governing our outstanding notes. We may decide to incur additional secured or unsecured debt in the future to finance our operations and any judgments or settlements or for other business purposes.

Our Credit Agreement provides for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Based on our eligible receivables, approximately $998 million was available for borrowing under the Credit Agreement at December 31, 2016. Our LC Facility provides for the issuance of standby and documentary letters of credit in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). At December 31, 2016, we had no cash borrowings outstanding under the Credit Agreement, and we had approximately $110 million of standby letters of credit outstanding in the aggregate under the Credit Facility and the LC Facility. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

The utilization of our tax losses could be substantially limited if we experience an ownership change as defined in the Internal Revenue Code.

At December 31, 2016, we had federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax available to offset future taxable income. These NOL carryforwards will expire in the years 2025 to 2034. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income that may be offset by the NOL carryforwards if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an

annual limitation and will depend on the amount of taxable income we generate in future periods. There is no assurance that we will be able to fully utilize the NOL carryforwards. Furthermore, we could be required to record a valuation allowance related to the amount of the NOL carryforwards that may not be realized, which could adversely impact our results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The disclosure required under this Item is included in Item 1, Business, of Part I of this report.

ITEM 3. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 14 to our Consolidated Financial Statements, which is incorporated by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II.

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

Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock on the NYSE:

	High	Low
Year Ended December 31, 2016		
First Quarter	$ 30.07	$ 21.39
Second Quarter	34.08	25.71
Third Quarter	31.84	20.93
Fourth Quarter	24.13	14.06
Year Ended December 31, 2015		
First Quarter	$ 52.69	$ 41.47
Second Quarter	59.21	46.33
Third Quarter	60.93	35.76
Fourth Quarter	39.75	26.60

On February 17, 2017, the last reported sales price of our common stock on the NYSE composite tape was $19.37 per share. As of that date, there were 4,254 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

Cash Dividends on Common Stock. We have not paid cash dividends on our common stock since the first quarter of fiscal 1994. We currently intend to retain future earnings, if any, for the operation and development of our business and, accordingly, do not currently intend to pay any cash dividends on our common stock. Our board of directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to pay any cash dividends in the future. Our senior secured revolving credit agreement and our letter of credit facility agreement contain provisions that limit the payment of cash dividends on our common stock if we do not meet certain financial ratios.

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

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to (i) the following indices (each of which was included in the stock performance graph presented in our Annual Report on Form 10-K for the year ended December 31, 2015) and a (ii) new index that we adopted in 2016. The previously disclosed indices are:

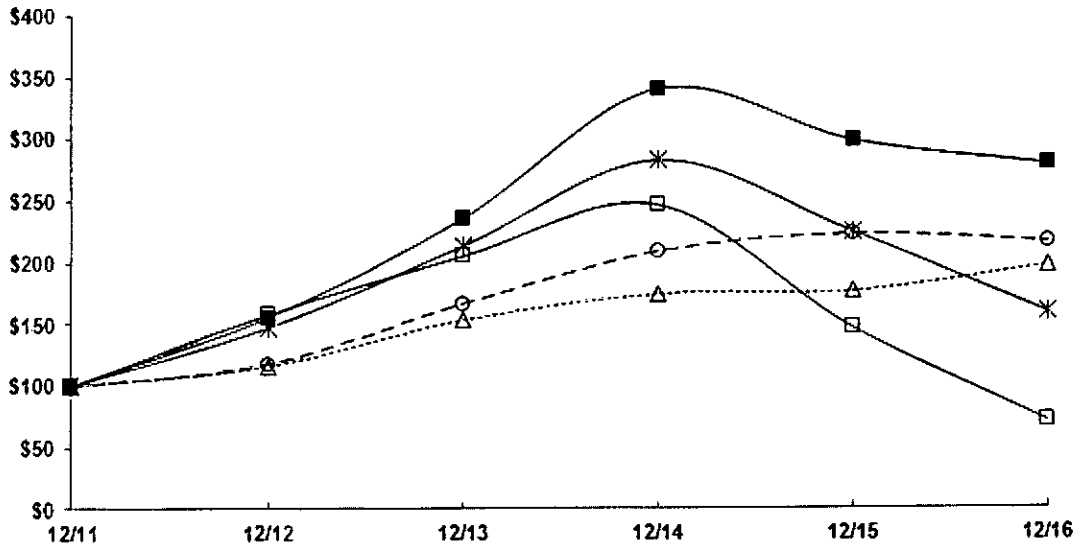
- Standard & Poor's 500 Stock Index (a broad equity market index in which we are not included);
- Standard & Poor's Health Care Composite Index (a published industry index in which we are not included); and
- A group made up of us and our hospital company peers (namely, Community Health Systems, Inc. (CYH), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS)), which we refer to as the "Old Peer Group".

In 2016, we modified the Old Peer Group to add HCA Holdings, Inc. (HCA) and LifePoint Health, Inc. (LPNT), each of which, like the other companies included in the Old Peer Group, is a publicly traded company conducting as its primary business the management of acute care hospitals. We added HCA, which became a public reporting company again in

2011, to the previously disclosed peer group because a full five years of performance data for its common stock became available at December 31, 2016. We added LPNT to the peer group because we believe many investors consider LPNT to be one of our peers when evaluating our performance. We refer to the modified peer group as the "New Peer Group" and, in accordance with SEC requirements, include it with the Old Peer Group on the chart below.

Performance data assumes that $100.00 was invested on December 31, 2011 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. The stock price performance shown in the graph is not necessarily indicative of future stock price performance. The performance graph shall not be deemed "filed" for purposes of Section 18 of the Exchange Act or incorporated by reference into any of our filings under the Securities Act or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

COMPARISON OF FIVE YEAR CUMULATIVE TOTAL RETURN



	12/11	12/12	12/13	12/14	12/15	12/16
Tenet Healthcare Corporation	$ 100.00	$ 158.24	$ 205.26	$ 246.93	$ 147.66	$ 72.32
S&P 500	$ 100.00	$ 116.00	$ 153.58	$ 174.60	$ 177.01	$ 198.18
S&P Health Care	$ 100.00	$ 117.89	$ 166.76	$ 209.02	$ 223.42	$ 217.41
Old Peer Group	$ 100.00	$ 147.21	$ 213.62	$ 283.42	$ 225.22	$ 159.72
New Peer Group	$ 100.00	$ 155.24	$ 235.16	$ 339.64	$ 298.31	$ 279.16

ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2012 through 2016. Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into our new USPI joint venture. The table below includes USPI results in the 2015 column for the post-acquisition period only. We acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013. The 2013 columns in the tables below include results of operations for Vanguard and its consolidated subsidiaries for the three months ended December 31, 2013 only. All amounts related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for the one-for-four reverse stock split we announced on October 1, 2012. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2016	2015	2014	2013	2012
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts	$ 21,070	$ 20,111	$ 17,908	$ 12,059	$ 9,896
Less: Provision for doubtful accounts	1,449	1,477	1,305	972	785
Net operating revenues	19,621	18,634	16,603	11,087	9,111
Equity in earnings of unconsolidated affiliates	131	99	12	15	8
Operating expenses:					
Salaries, wages and benefits	9,356	9,011	8,023	5,371	4,257
Supplies	3,124	2,963	2,630	1,784	1,552
Other operating expenses, net	4,891	4,555	4,114	2,701	2,147
Electronic health record incentives	(32)	(72)	(104)	(96)	(40)
Depreciation and amortization	850	797	849	545	430
Impairment and restructuring charges, and acquisition-related costs	202	318	153	103	19
Litigation and investigation costs, net of insurance recoveries	293	291	25	31	5
Gains on sales, consolidation and deconsolidation of facilities	(151)	(186)	—	—	—
Operating income	1,219	1,056	925	663	749
Interest expense	(979)	(912)	(754)	(474)	(412)
Loss from early extinguishment of debt	—	(1)	(24)	(348)	(4)
Investment earnings	8	1	—	1	1
Income (loss) from continuing operations, before income taxes	248	144	147	(158)	334
Income tax benefit (expense)	(67)	(68)	(49)	65	(125)
Income (loss) from continuing operations, before discontinued operations	181	76	98	(93)	209
Less: Preferred stock dividends	—	—	—	—	11
Less: Net income attributable to noncontrolling interests from continuing operations	368	218	64	30	13
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders from continuing operations	$ (187)	$ (142)	$ 34	$ (123)	$ 185
Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	$ (1.88)	$ (1.43)	$ 0.35	$ (1.21)	$ 1.77
Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	$ (1.88)	$ (1.43)	$ 0.34	$ (1.21)	$ 1.70

The operating results data presented above is not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services ("CMS") of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters 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 or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures.

BALANCE SHEET DATA

	December 31,				
	2016	2015	2014	2013	2012
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 1,223	$ 863	$ 393	$ 599	$ 918
Total assets	24,701	23,682	17,951	16,450	9,044
Long-term debt, net of current portion	15,064	14,383	11,505	10,696	5,158
Redeemable noncontrolling interests in equity of consolidated subsidiaries	2,393	2,266	401	340	16
Noncontrolling interests	665	267	134	123	75
Total equity	1,082	958	785	878	1,218

CASH FLOW DATA

	Years Ended December 31,				
	2016	2015	2014	2013	2012
	(In Millions)				
Net cash provided by operating activities	$ 558	$ 1,026	$ 687	$ 589	$ 593
Net cash used in investing activities	(430)	(1,317)	(1,322)	(2,164)	(662)
Net cash provided by financing activities	232	454	715	1,324	320

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our Hospital Operations and other segment is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals, physician practices and health plans (certain of which are classified as held for sale as described in Note 4 to our Consolidated Financial Statements). Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI joint venture"), in which we own a majority interest, and European Surgical Partners Limited ("Aspen") facilities. At December 31, 2016, our USPI joint venture had interests in 239 ambulatory surgery centers, 34 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 27 states, and Aspen operated nine private hospitals and clinics in the United Kingdom. Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities, through our Conifer Holdings, Inc. ("Conifer") subsidiary. MD&A, which should be read in conjunction with the accompanying Consolidated Financial Statements, includes the following sections:

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

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 67 hospitals and six health plans operated throughout the years ended December 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) Saint Louis University Hospital ("SLUH"), which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) our two North Carolina hospitals, which we divested effective January 1, 2016, (x) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (xi) our five Georgia hospitals, which we divested effective April 1, 2016, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to December 31, 2016, 2015 and 2014, as applicable. 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

Welsh Carson Put Notice—In January 2017, subsidiaries of Welsh, Carson, Anderson & Stowe delivered a put notice for the minimum number of shares (representing a 6.25% ownership interest in our USPI joint venture) that they are required to put to us in 2017 according to our Put/Call Agreement, as described and defined in Note 15 to our Consolidated Financial Statements. The parties are in discussions regarding the calculation of the estimated purchase

price relating to the exercise of the 2017 put option as contemplated by the Put/Call agreement. The estimated purchase price is based on an agreed-upon estimate of 2017 financial results and is subject to true-up following the finalization of actual 2017 financial results. However, we anticipate that the initial estimated payment will be between $159 million and $170 million. In addition, we are currently evaluating the additional call options available to us pursuant to the Put/Call Agreement.

TRENDS AND STRATEGIES

The healthcare industry, in general, and the acute care hospital business, in particular, are experiencing significant regulatory uncertainty based, in large part, on legislative 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 these actions on our future revenues and operations. However, we believe that our ultimate success in increasing our profitability depends in part on our success in executing the strategies discussed below. In general, these strategies are intended to address the following trends shaping the demand for healthcare services: (i) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (ii) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (iii) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (iv) consolidation continues across the entire healthcare sector through both traditional acquisition and divestiture activities, as well as joint ventures.

Driving Growth in Our Facilities—Over the past several years, and with the aforementioned trends in mind, we have taken a number of steps to better position our hospitals, ambulatory care centers and other outpatient businesses to compete more effectively in the ever evolving healthcare environment. We have set competitive prices for our services, made capital and other investments in our facilities and technology, increased our efforts to recruit and retain quality physicians, nurses and other healthcare personnel, and negotiated competitive contracts with managed care and other private payers. In addition, we have expanded our network of outpatient centers, and we have increased the participation of our hospitals in accountable care organizations ("ACOs"), which are networks of providers and suppliers that work together to invest in infrastructure and to redesign delivery processes in an effort to achieve high quality and efficient delivery of services. We have also entered into joint ventures with other healthcare providers in several of our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

We believe we are well-positioned to generate returns on recent hospital projects, including our new 106-bed teaching hospital in El Paso, which opened on January 17, 2017. We are also continuing our strategy of selling assets in non-core markets, such as our former hospitals and related operations in Georgia and North Carolina, as well as sub-scale businesses, such as our health plans. We will continue to further refine our portfolio of hospitals and related healthcare businesses when we believe such refinements will help us achieve one or more of the following goals: improve profitability; allocate capital more effectively in areas where we have a stronger market presence; deploy proceeds on higher-return investments across our business; enhance cash generation; and lower our ratio of debt-to-Adjusted EBITDA.

Expansion of Our Ambulatory Care Segment—We remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We believe surgery centers and surgical hospitals like those in our USPI joint venture 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 in a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. In addition, we have continued to grow our imaging and urgent care businesses through our USPI joint venture's acquisitions. These acquisitions reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services. We intend to increase our ownership in our USPI joint venture each year using internally generated cash with the expectation that we will own approximately 95% of the total outstanding USPI joint venture shares between 2018 and 2020.

Driving Conifer's Growth—We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and value-based care services businesses. Conifer provides services to more than 800 Tenet and non-Tenet hospital and other clients nationwide. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward ACOs and similar risk-based or capitated contract models. In addition to hospitals and independent physician associations, clients for these services include health plans, self-insured organizations, government agencies and other entities.

Improving Operating Leverage—We are focused on improving profitability by growing patient volumes and effective cost management. We believe our patient volumes have been constrained 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 and deductibles, depressed economic conditions in certain of our markets and demographic trends. However, we also believe that targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our outpatient business and the implementation of new payer contracting strategies should help us grow our patient volumes. In addition, we believe our capital structure will withstand a changing interest rate environment. Approximately 94% of our long-term debt has a fixed rate of interest, and the maturity dates of our notes are staggered from 2018 through 2031. Moreover, we intend to lower our ratio of debt-to-Adjusted EBITDA, primarily through Adjusted EBITDA growth, which should lower our refinancing risk and increase the potential for us to use lower-rate secured debt to refinance portions of our higher-rate unsecured debt.

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

RESULTS OF OPERATIONS—OVERVIEW

We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2016 and 2015 on a continuing operations basis.

Selected Operating Statistics for All Continuing Operations Hospitals— The following table shows certain selected operating statistics for our continuing operations, which includes the results of (i) our same 67 hospitals and six health plans operated throughout three months ended December 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) SLUH, which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) our two North Carolina hospitals, which we divested effective January 1, 2016, (x) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (xi) our five Georgia hospitals, which we divested effective April 1, 2016, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to December 31, 2016 and 2015, as applicable. We believe this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses.

Selected Operating Statistics	Continuing Operations Three Months Ended December 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Number of hospitals (at end of period)	75	86	(11)[1]
Total admissions	192,104	211,991	(9.4)%
Adjusted patient admissions[2]	338,929	371,994	(8.9)%
Paying admissions (excludes charity and uninsured)	181,617	200,462	(9.4)%
Charity and uninsured admissions	10,487	11,529	(9.0)%
Emergency department visits	701,100	778,148	(9.9)%
Total surgeries	126,749	138,264	(8.3)%
Patient days — total	888,185	983,856	(9.7)%
Adjusted patient days[2]	1,543,490	1,710,620	(9.8)%
Average length of stay (days)	4.62	4.64	(0.4)%
Average licensed beds	20,326	22,549	(9.9)%
Utilization of licensed beds[3]	47.5 %	47.4 %	0.1 %[1]
Total visits	1,950,549	2,198,005	(11.3)%
Paying visits (excludes charity and uninsured)	1,834,844	2,024,725	(9.4)%
Charity and uninsured visits	115,705	173,280	(33.2)%
Ambulatory Care			
Total consolidated facilities (at end of period)	215	192	23 [1]
Total cases	445,107	289,033	54.0 %

(1) The change is the difference between the 2016 and 2015 amounts shown.
(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Total admissions decreased by 19,887, or 9.4%, in the three months ended December 31, 2016 compared to the three months ended December 31, 2015. Total surgeries decreased by 8.3% in the three months ended December 31, 2016 compared to the same period in 2015. Our emergency department visits decreased 9.9% in the three months ended December 31, 2016 compared to the same period in the prior year. Our volumes from continuing operations were negatively impacted by the decrease in our number of hospitals; however, we believe the volume decreases were partially offset by the growth we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy. Our Ambulatory Care total cases increased 54.0% due to our USPI joint venture's acquisition of 35 urgent care centers (one of which has since been closed) effective December 31, 2015, as well as the impact associated with stepping up our USPI joint venture's ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

Revenues	Continuing Operations Three Months Ended December 31, 2016	2015	Increase (Decrease)
Net operating revenues before provision for doubtful accounts	$ 5,214	$ 5,417	(3.7)%
Hospital Operations and other			
Revenues from charity and the uninsured	$ 287	$ 267	7.5 %
Net inpatient revenues[1]	$ 2,606	$ 2,736	(4.8)%
Net outpatient revenues[1]	$ 1,457	$ 1,616	(9.8)%
Ambulatory Care revenues	$ 478	$ 397	20.4 %
Conifer revenues	$ 402	$ 384	4.7 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $127 million and $96 million for the three months ended December 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $160 million and $171 million for the three months ended December 31, 2016 and 2015, respectively.

Net operating revenues before provision for doubtful accounts decreased by $203 million, or 3.7%, in the three months ended December 31, 2016 compared to the same period in 2015, primarily due to lower inpatient and outpatient volumes as a result of the decrease in our number of hospitals. For our Hospital Operations and other segment, the impact of lower volumes on net operating revenues was partially mitigated by improved managed care pricing.

	Continuing Operations Three Months Ended December 31,		
Provision for Doubtful Accounts	2016	2015	Increase (Decrease)
Provision for doubtful accounts	$ 354	$ 391	(9.5)%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	6.8 %	7.2 %	(0.4)%[1]

(1) The change is the difference between the 2016 and 2015 amounts shown.

Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 6.8% and 7.2% for the three months ended December 31, 2016 and 2015, respectively. This improvement was primarily due to the growth in our Ambulatory Care segment, where bad debt expense is a much smaller percentage of revenues relative to our hospitals. Our accounts receivable days outstanding ("AR Days") from continuing operations were 54.8 days at December 31, 2016 and 49.5 days at December 31, 2015, within our target of less than 55 days.

	Continuing Operations Three Months Ended December 31,		
Selected Operating Expenses	2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,925	$ 2,075	(7.2)%
Supplies	674	738	(8.7)%
Other operating expenses	1,034	1,067	(3.1)%
Total	$ 3,633	$ 3,880	(6.4)%
Ambulatory Care			
Salaries, wages and benefits	$ 157	$ 130	20.8 %
Supplies	99	79	25.3 %
Other operating expenses	83	78	6.4 %
Total	$ 339	$ 287	18.1 %
Conifer			
Salaries, wages and benefits	$ 242	$ 238	1.7 %
Other operating expenses	88	85	3.5 %
Total	$ 330	$ 323	2.2 %
Total			
Salaries, wages and benefits	$ 2,324	$ 2,443	(4.9)%
Supplies	773	817	(5.4)%
Other operating expenses	1,205	1,230	(2.0)%
Total	$ 4,302	$ 4,490	(4.2)%
Rent/lease expense[1]			
Hospital Operations and other	$ 62	$ 67	(7.5)%
Ambulatory Care	19	15	26.7 %
Conifer	4	4	— %
Total	$ 85	$ 86	(1.2)%

(1) Included in other operating expenses.

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended December 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits per adjusted patient admission[1]	$ 5,680	$ 5,577	1.8 %
Supplies per adjusted patient admission[1]	1,989	1,984	0.3 %
Other operating expenses per adjusted patient admission[1]	3,074	2,890	6.4 %
Total per adjusted patient admission	$ 10,743	$ 10,451	2.8 %

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

Salaries, wages and benefits per adjusted patient admission increased 1.8% in the three months ended December 31, 2016 compared to the same period in 2015. This change is primarily due to annual merit increases for certain of our employees and the effect of lower volumes on operating leverage due to the sale of certain of our hospitals since the 2015 period, partially offset by decreased accruals for annual incentive compensation, in the three months ended December 31, 2016 compared to the three months ended December 31, 2015.

Supplies expense per adjusted patient admission increased 0.3% in the three months ended December 31, 2016 compared to the three months ended December 31, 2015. The change in supplies expense was primarily attributable to growth in our higher acuity supply-intensive surgical services, partially offset by the impact of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

Other operating expenses per adjusted patient admission increased by 6.4% in the three months ended December 31, 2016 compared to the three months ended December 31, 2015. This increase is due to higher contracted services and medical fees, the effect of lower volumes on operating leverage due to the sale of certain of our hospitals since the 2015 period, and increased costs associated with our health plans due to an increase in covered lives, which costs were partially offset by increased health plan revenues. Malpractice expense for our Hospital Operations and other segment was $33 million lower in the 2016 period compared to the 2015 period. The 2016 period included a favorable adjustment of approximately $19 million due to an 83 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $7 million as a result of a 34 basis point increase in the interest rate in the 2015 period.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $716 million at December 31, 2016 compared to $649 million at September 30, 2016.

Significant cash flow items in the three months ended December 31, 2016 included:

- Net cash provided by operating activities before interest, taxes and restructuring charges, acquisition-related costs, and litigation costs and settlements of $613 million;
- Payments for restructuring charges, acquisition-related costs and litigation costs and settlements of $559 million, which payments include approximately $517 million related to our Clinica de la Mama matter, which is described in Note 14 to our Consolidated Financial Statements;
- Capital expenditures of $261 million;
- Purchases of businesses or joint venture interests of $21 million;
- Interest payments of $336 million;
- $750 million proceeds from the issuance of our 7½% senior secured notes due 2022; and

- $67 million of distributions paid to our noncontrolling interests.

Net cash provided by operating activities was $558 million in the year ended December 31, 2016 compared to $1.026 billion in the year ended December 31, 2015. Key positive and negative factors contributing to the change between the 2016 and 2015 periods include the following:

- Increased income from continuing operations before income taxes of $137 million, excluding investment earnings (losses), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the year ended December 31, 2016 compared to the year ended December 31, 2015;

- An increase of $491 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;

- Approximately $84 million of additional net cash proceeds in the 2016 period related to supplemental Medicaid programs in California and Texas;

- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $18 million and $9 million, respectively, in the year ended December 31, 2016 compared to the year ended December 31, 2015;

- Higher interest payments of $73 million.

- A $15 million decrease in cash used in discontinued operations; and

- The timing of other working capital items.

SOURCES OF REVENUE

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

The table below shows the sources of net patient revenues before provision for doubtful accounts for our Hospital Operations and other segment, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Years Ended December 31,		
Net Patient Revenues from:	2016	2015	2014
Medicare	20.5 %	20.4 %	22.0 %
Medicaid	8.2 %	8.7 %	9.6 %
Managed care	61.5 %	60.6 %	58.4 %
Indemnity, self-pay and other	9.8 %	10.3 %	10.0 %

Our payer mix on an admissions basis for our Hospital Operations and other segment, expressed as a percentage of total admissions from all sources, is shown below:

	Years Ended December 31,		
Admissions from:	2016	2015	2014
Medicare	26.1 %	26.7 %	27.5 %
Medicaid	7.0 %	8.0 %	10.3 %
Managed care	59.2 %	57.5 %	54.5 %
Indemnity, self-pay and other	7.7 %	7.8 %	7.7 %

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 55 million individuals rely on healthcare benefits through Medicare, and approximately 74 million individuals are enrolled in Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and directed by CMS. Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

The Affordable Care Act

Several provisions of the ACA, including premium assistance and cost sharing subsidies for insurance products purchased through the health insurance exchanges, and the expansion of Medicaid in the 31 states (including six in which we operate acute hospitals) and the District of Columbia that have taken action to do so, are financed through:

- negative adjustments to the annual market basket updates for Medicare hospital inpatient, outpatient, prospective payment systems, which began in 2010, as well as additional negative "productivity adjustments" to the annual market basket updates which began in 2011; and

- reductions to Medicare and Medicaid disproportionate share hospital ("DSH") payments, which began for Medicare payments in federal fiscal year ("FFY") 2014 and will begin for Medicaid payments in FFY 2018.

We cannot predict if or when modification or repeal of the ACA will take effect or what action, if any, Congress might take with respect to replacing the law. We are also unable to predict the impact of legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in FFY 2018) are made.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues from continuing operations of our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2016, 2015 and 2014 are set forth in the following table:

Revenue Descriptions	Years Ended December 31, 2016	2015	2014
Medicare severity-adjusted diagnosis-related group — operating	$ 1,705	$ 1,744	$ 1,677
Medicare severity-adjusted diagnosis-related group — capital	157	161	154
Outliers	77	61	69
Outpatient	927	953	896
Disproportionate share	293	337	370
Direct Graduate and Indirect Medical Education[1]	249	256	250
Other[2]	63	5	98
Adjustments for prior-year cost reports and related valuation allowances	55	62	30
Total Medicare net patient revenues	**$ 3,526**	**$ 3,579**	**$ 3,544**

(1) Includes Indirect Medical Education revenues earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.

(2) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

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

Acute Care Hospital Inpatient Prospective Payment System

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

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

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

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

Disproportionate Share Hospital Payments—In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately high share of low-income patients. Prior to October 1, 2013, DSH payments were determined annually based on certain statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. The ACA revised the Medicare DSH adjustment effective for discharges occurring on or after October 1, 2014. Under the revised methodology, hospitals receive 25% of the amount they previously would have received under the pre-ACA formula. This amount is referred to as the "Empirically Justified Amount."

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC DSH Amount"). The UC DSH Amount is a hospital's share of a pool of funds that equal 75% of what otherwise would have been paid as Medicare DSH, adjusted for changes in the percentage of individuals that are uninsured. Generally, the factors used to calculate and distribute the UC DSH pool are set forth in the ACA and are not subject to administrative or judicial review. The annual estimate of the size of the UC DSH pool is made by the CMS Office of the Actuary and is based on the projections of total DSH payments that would have been made under the pre-ACA formula. Although the statute requires that each hospital's cost of uncompensated care as a percentage of the total uncompensated care cost of all DSH hospitals be used to allocate the pool, CMS determined that the available cost data from cost reports was unreliable and is using low income days (i.e., Medicaid days) to distribute the pool. For FFY 2017, CMS is using low income days to allocate the UC DSH pool. In the FFY 2017 IPPS Final Rule, CMS stated that: (1) it expected uncompensated care cost data would be available for distribution of the UC DSH pool no later than FFY 2021, and (2) it would explore whether there is an appropriate proxy for uncompensated care cost that could be used to allocate the UC DSH pool until the agency determines that the data from the cost reports can be used for that purpose. We cannot predict what action, if any, CMS will take, the timing of such action, or what impact such action will have on our net revenues and cash flows.

During 2016, 66 of our acute care hospitals in continuing operations qualified for Medicare DSH payments. One of the variables used in the pre-ACA DSH formula is the number of Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Original Medicare Plan patients, but also Medicare Advantage patients in the SSI ratio. The statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates ("FFY 2005 Final Rule"). We are not able to predict what action the Secretary might take with respect to the DSH calculation in this regard; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") payments. During 2016, 26 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments.

Hospital Outpatient Prospective Payment System

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

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient

prospective payment system. The IPF-PPS is based on prospectively determined per-diem rates and includes an outlier policy that authorizes additional payments for extraordinarily costly cases. During 2016, 27 of our general hospitals operated IPF units.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system. During 2016, we operated one freestanding IRF, and 21 of our general hospitals operated IRF units.

Physician Services Payment System

Medicare pays for physician and other professional services based on a list of services and their payment rates called the Medicare Physician Fee Schedule ("MPFS"). In determining payment rates for each service on the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations and other factors. Beginning in CY 2017, the payments for physician services will be based on the provisions prescribed by The Medicare Access and Children's Health Insurance Program Act ("MACRA") that was signed into law on April 16, 2015 as described below.

Cost Reports

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

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

Medicare Claims Reviews

HHS estimates that approximately 11% of all Medicare Fee-For-Service ("FFS") claim payments in FFY 2016 were improper. CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. CMS has established several initiatives to prevent or identify improper payments before a claim is paid, and to identify and recover improper payments after paying a claim. The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types. Under the authority of the Act, CMS employs a variety of contractors (e.g., Medicare Administrative Contractors and Recovery Audit Contractors) to process and review claims according to Medicare rules and regulations.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment and post payment claims denials are subject to administrative and judicial review, and we intend to pursue the reversal of adverse determinations where appropriate. We have established robust protocols to

respond to claims reviews and payment denials. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 17.2%, 18.3% and 18.1% of total net patient revenues before provision for doubtful accounts for the years ended December 31, 2016, 2015 and 2014, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the years ended December 31, 2016, 2015 and 2014, our total Medicaid supplemental revenues attributable to DSH and other supplemental revenues were approximately $906 million, $888 million and $817 million, respectively. The $906 million of total Medicaid supplemental revenues attributable to DSH and other supplemental revenues for the year ended December 31, 2016 was comprised of $232 million related to the California Provider Fee program, $228 million related the Michigan Provider Fee program, $176 million related to Medicaid DSH programs in multiple states, $142 million related to the Texas 1115 waiver program, and $128 million from a number of other state and local based programs.

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

The California Department of Health Care Services (DHCS) implemented its first Hospital Quality Assurance Fee ("HQAF") program in 2010. The HQAF program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The fourth and most recent phase of the program ("HQAF IV") covering the period January 2014 through December 2016 was authorized by legislation enacted in October 2013 and approved by CMS in the three months ended December 31, 2014. Under this program, our hospitals recognized revenues, net of provider fees and other expenses, of approximately $232 million, $188 million and $165 million in calendar years 2016, 2015 and 2014, respectively. In November 2016, California voters approved a state constitutional amendment measure that extends indefinitely the statute that imposes fees on hospitals to obtain federal matching funds. However, the current program expired on December 31, 2016 and CMS has not approved a new program. Consistent with the first four phases of the HQAF program, net revenue associated with HQAF V will not be recognized until CMS issues the required approvals. Because the HQAF supplemental payments are partially funded by the federal government, each phase of the program must be approved by CMS, and the approval process can be lengthy. With the expiration of the HQAF IV program on December 31, 2016, we anticipate that: (1) during the three months ending March 31, 2017 the state will submit to CMS a request for approval of a 30-month program covering the period January 2017 through June 2019 ("HQAF V"); and (2) CMS approval of the HQAF V may occur as early as late 2017, although we cannot provide any assurances in regard to either. Because HQAF funding levels are based in part on Medi-Cal utilization, changes in coverage of individuals under the Medi-Cal program could affect the net revenues and cash flows of our hospitals under HQAF V and subsequent phases of the HQAF program. Accordingly, we are unable to predict the amount of net revenues our hospitals may receive from or the timing of CMS' approval of the HQAF V program.

Certain of our Texas hospitals participate in the Texas 1115 waiver program. The current waiver term expires on December 31, 2017, is funded by intergovernmental transfer payments from local government entities, and includes two funding pools – Uncompensated Care and Delivery System Reform Payment. In 2016, we recognized $142 million

of revenues from the Texas 1115 waiver program. Separately, during the same period, we incurred $79 million of expenses related to funding indigent care services by certain of our Texas hospitals. On September 30, 2016, the State of Texas submitted a request to CMS to extend the 1115 waiver program for a period of five years. We cannot provide any assurances as to the extension of the 1115 waiver program, or the ultimate amount of revenues that our hospitals may receive from this program in 2017 or future periods.

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

Medicaid-related patient revenues from continuing operations recognized by our Hospital Operations and other segment from Medicaid-related programs in the states in which our hospitals are located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2016, 2015 and 2014 are set forth in the table below:

	Years Ended December 31,					
	2016		2015		2014	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
California	$ 401	$ 417	$ 343	$ 401	$ 311	$ 257
Michigan	349	314	366	306	337	270
Texas	235	231	264	237	280	223
Florida	95	166	97	162	158	103
Alabama	80	—	37	—	12	—
Pennsylvania	80	199	66	206	73	194
Illinois	37	69	88	50	80	32
Massachusetts	37	52	37	50	39	46
South Carolina	16	34	16	33	18	34
Georgia	11	8	69	39	73	36
Tennessee	5	34	6	32	7	29
Missouri	2	—	50	14	67	9
Arizona	—	199	(16)	195	1	113
North Carolina	(2)	—	28	6	26	5
	$ 1,346	$ 1,723	$ 1,451	$ 1,731	$ 1,482	$ 1,351

Regulatory and Legislative Changes

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

Final Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year ("FFY"). On August 2, 2016, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2017 Rates. On September 30, 2016, CMS issued a notice that corrects technical and typographical errors in the August 2, 2016 rule. The August 2, 2016 final rule and the September 30, 2016 correction

notice are hereinafter referred to as the "Final IPPS Rule". The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.7% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record ("EHR") technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS is also making certain adjustments to the 2.7% market basket increase that result in a net operating payment update to the operating standardized amount of 0.95% (before budget neutrality adjustments), including:
    - Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.3%, respectively;
    - A documentation and coding recoupment reduction of 1.5% as required by the American Taxpayer Relief Act of 2012;
    - Prospective reversal of the 0.2% reduction related to the two-midnight rule that was first imposed in FFY 2014; and
    - A one-time increase of 0.6% to reverse the 0.2% two-midnight rule reductions imposed in FFYs 2014 through 2016.
- Updates to the factors and methodology used to determine the amount and distribution of Medicare uncompensated care disproportionate share ("UC-DSH") payments;
- A 1.84% net increase in the capital federal MS-DRG rate; and
- An increase in the cost outlier threshold from $22,544 to $23,573.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 0.9% increase in operating MS-DRG payments for hospitals in large urban areas (populations over one million) in FFY 2017. The final payment and policy changes affecting operating MS-DRG payments and other rules, including those affecting Medicare UC-DSH payments, result in an estimated 0.5% increase in our annual IPPS payments, which yields an estimated increase of approximately $11 million in our annual Medicare IPPS payments. Because of the uncertainty regarding factors that may influence our future IPPS payments by individual hospital, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

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

On November 1, 2016, CMS released the final policy changes, quality provisions and payment rates for the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year 2017 ("Final OPPS/ASC Rule"). The Final OPPS/ASC rule includes the following changes:

- An net increase in the OPPS rates of 1.65% based on an estimated market basket increase of 2.7% reduced by market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.3%, respectively;
- Policies to implement Section 603 of the Bipartisan Budget Act of 2015, which requires that certain items and services furnished by certain off-campus hospital departments shall not be considered covered outpatient department services for purposes of OPPS payments and shall instead be paid "under the applicable payment system" which, beginning January 1, 2017, is approximately 50% of the OPPS rate;

- The removal of five spine procedure codes and two laryngoplasty codes from the CMS list of procedures that can be performed only on an inpatient basis (the "Inpatient Only List");

- A 1.9% update to the ASC payment rates; and

- Reducing the Electronic Health Record reporting period for 2016 and 2017 from 12 months to a consecutive 90-day period.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS/ASC Rule will yield an average 1.7% increase in OPPS payments for all facilities and an average 1.7% increase in OPPS payments for hospitals in large urban areas (populations over one million). Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS/ASC Rule on our hospitals is an increase to Medicare outpatient revenues of approximately $15 million. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative action, volumes and case mix, we cannot provide any assurances regarding our estimate of the impact of the changes.

The Medicare Access and CHIP Reauthorization Act of 2015

The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") replaces the Medicare Sustainable Growth Rate methodology with a new system for establishing the annual updates to payment rates for physician services in Medicare that, beginning in 2019, rewards the delivery of high-quality patient care through one of two avenues:

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

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

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

Additionally, the MACRA reduces the restoration of the 3.2% coding and document adjustment to hospital inpatient rates that was expected to be effective in FFY 2018. Under the legislation, the reduced amount is 3.0% and will be applied at the rate of 0.5% over six years beginning in FFY 2018. This provision was subsequently modified by the 21st Century Cures Act of 2016 as described below.

On October 14, 2016, CMS issued a final rule implementing MACRA. In the final rule, CMS made several changes to the proposed rule including:

- Reducing the MIPS reporting burden in the first performance year (2017). Per the final rule, providers may begin reporting under MIPS at any time between January 1, 2017 and October 2, 2017 and can avoid a payment penalty in 2019 by reporting as little as one quality measure or one improvement activity. CMS also reduced the thresholds by which a provider in a small practice must participate.

- Changes to the APMs (including the Comprehensive Care and Joint Replacement ("CJR") model) that will be eligible as Advanced APMs for bonus payment purposes.

Less than 1% of the net operating revenue generated by our Hospital Operations and other segment during the year ended December 31, 2016 was related to the Medicare fee-for-service Physician Fee Schedule. We are unable to estimate the potential impact of MACRA; however, the maximum incentive and penalty adjustments could result in an increase or decrease in our annual net revenues of approximately $15 million. Additionally, we cannot predict the effect of MACRA on our future operations, revenues and cash flows.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On November 2, 2016, CMS issued a final rule updating the MPFS for calendar year 2017 ("MPFS Final Rule"). This final rule updates payment policies, payment rates, and other provisions for services furnished under the MPFS on or after January 1, 2017. In addition to policies affecting the calculation of payment rates, the final rule identifies potentially misvalued codes, adds procedures to the telehealth list, and finalizes a number of new policies, including several that are a result of recently enacted legislation. As a result of the final rule, the MPFS conversion factor for 2017 will increase by 0.24%. CMS estimates that the impact of the payment and policy changes in the final rule will result in no change in aggregate payments across all specialties.

Bipartisan Budget Act of 2015

On November 2, 2015, the President signed the Bipartisan Budget Act of 2015 ("BBA 2015"). The legislation raises the debt ceiling through March 2017 and establishes a federal budget through FFY 2017. The BBA 2015 includes the following payment policies affecting Medicare beneficiaries, hospitals and other providers:

- Medicare Part B premium relief for the 30% of beneficiaries facing massive increases beginning in 2016;
- An extension through FFY 2025 of a 2% reduction (referred to as the "sequestration adjustment") to all Medicare payments, mandated by the Budget Control Act of 2011, that was originally scheduled to expire in 2021 and subsequently extended through 2024; and
- Creation of a site-neutral payment policy for services provided in off-campus outpatient departments of hospitals. This provision:
    - Creates a permanent exemption from site-neutral payment adjustments for off-campus hospital-based emergency departments;
    - Grandfathers off-campus hospital outpatient departments that billed for services under the OPPS as of the date of enactment; and
    - Provides that, beginning January 1, 2017, off-campus hospital outpatient departments that are not grandfathered or exempt will be paid under the MPFS or ASC fee schedule (this measure was amended by the 21st Century Cures Act as described below).

The American Recovery and Reinvestment Act of 2009

ARRA was enacted to stimulate the U.S. economy. One provision of ARRA provides financial incentives to hospitals and physicians to become "meaningful users" of electronic health records. The Medicare incentive payments to individual hospitals are made over a four-year, front-weighted transition period. The Medicaid incentive payments, which are funded by the federal government and administered by the states, are subject to separate payment policies.

During the year ended December 31, 2016, we recognized approximately $32 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of certain of our hospitals, employed physicians and Ambulatory Care segment facilities demonstrating meaningful use of certified EHR technology and meeting the criteria for revenue recognition. The final Medicare EHR hospital incentive payments are determined when the cost report that begins in the federal fiscal year during which the hospital achieved meaningful use is settled. Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

We anticipate recognizing approximately $9 million of Medicare and Medicaid EHR incentive payments in 2017. In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Eligible hospitals must continue to demonstrate meaningful use of EHR technology every year to avoid payment reductions in subsequent years. These reductions, which will be based on the market basket update, will be phased in over three years and will continue until a hospital achieves compliance. Should all of our hospitals fail to become meaningful users (or fail to continue to demonstrate meaningful use) of EHRs and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of up to approximately $34 million in 2017 and subsequent years.

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

21st Century Cures Act

On December 13, 2016, the President signed the 21st Century Cures Act ("Cures Act") legislation intended to accelerate the "discovery, development and delivery" of medical therapies by encouraging biomedical research investment and facilitating innovation review and approval processes, and several other health-related measures, including changes affecting Medicare payments to hospitals and other providers, including:

- Relief for certain off-campus hospital-based sites that were under development from the provisions of section 603 of the Bipartisan Budget Act of 2015;
- Requiring CMS to develop Healthcare Common Procedure Coding System ("HCPCS") codes (used to code outpatient services) associated with 10 surgical MS-DRGs that commonly have a one-day length of stay to translate outpatient surgical codes into inpatient surgical MS-DRGs as one of the steps to help develop a unified hospital payment system; and
- Reducing the coding and documentation adjustment to inpatient hospital payment rates under the MACRA from an increase of 0.5 percentage points to an increase of 0.4588 percentage points in 2018.

CMS Innovation Models

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of Section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS. The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for communities and lower costs through improvement for our health care system. Generally, the models include ACOs and Episodic Bundled Payment Model ("EPM") initiatives. Participation in these programs is either voluntary or mandatory. For example, participation in the Shared Savings ACO is voluntary; whereas participation in certain bundled payment models is mandatory.

On December 20, 2016, CMS finalized new Innovation Center models that continue the progress toward shifting Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for healthcare providers to deliver better care to patients at a lower cost. These models are intended to avoid complications, prevent hospital readmissions, and speed recovery. In December 2016, CMS released a final rule, the Advancing Care Coordination Through Episode Payment Models ("EPMs") rule. This rule:

- makes changes to the current CJR demonstration to conform to the other EPMs;

- implements testing of three EPMs that address care of:
  - acute myocardial infarction ("AMI"),
  - coronary artery bypass graft ("CABG"), and
  - surgical hip/femur fracture treatment ("SHFFT").

- establishes the Cardiac Rehabilitation Incentive Payment Model ("CR"), designed to complement the AMI and CABG EPMs.

Participants for all four models (AMI, CABG, SHFFT, and CR) are IPPS acute care hospitals in selected geographic areas and participation is mandatory. Similar to the CJR, under the three new EPMs, inpatient and 90-day post-discharge payments will be retrospectively bundled, and quality-adjusted comparison of actual to target expenditures for each EPM hospital will result in reconciliation payments (from CMS to participants) or repayments (from participants to CMS). The first performance year for the new EPMs is scheduled to begin on July 1, 2017, and the demonstrations expire on December 31, 2021.

Currently, 20 of our acute care hospitals participate in the CJR and are expected to be required to participate in the SHFFT EPM, 12 of our acute care hospitals are expected to be required to participate in the AMI and CABG demonstrations, and 16 of our hospitals are expected to participate in the CR program. We cannot predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

Medicaid Managed Care Final Rule – Pass Through Payments

In a final rule issued in 2016, CMS stated that managed care regulations prohibit states from making payments to providers for services available under a contract between the state and the managed care plan, and the agency interprets those regulations to also prohibit states from making supplemental payments to providers (referred to as "pass-through" payments) through a managed care plan. In that rule, CMS: (1) stated its belief that pass-through payments are not actuarially sound because they do not tie provider payments to the provision of services and limited the managed care plans' ability to effectively manage care delivery, and (2) that it would allow states, managed care plans and providers 10 years to phase out pass-through payments. On January 17, 2017, CMS issued a Final Medicaid Managed Care rule that clarified and established additional policies regarding Medicaid managed care pass-through payments that will affect how Medicaid managed care supplemental payments are distributed to providers. Specifically,

- States may not create new pass-through payment programs;

- Pass-through payments that will be permitted through the phase down period will be limited to the rates that states had submitted to CMS as of July 5, 2016; and

- Although the change in CMS' policy results in a reduction of the pass-through payments over a 10-year period, states may instead implement new "Permissible Directed Payments" in Medicaid managed care programs, which could include uniform dollar or percentage increases in rates, minimum or maximum fee schedules.

In the January 17, 2017 final rule, CMS estimates that at least 16 states have implemented pass-through payments for hospitals, although the individual states are not identified. Some states in which we operate hospitals have established supplemental payment programs which include payments that may possibly meet CMS' definition of pass-through payments, and would, therefore, be subject to the provisions of the Medicaid Managed Care final rule. Although CMS' policy requires the gradual phase out of pass-through payments, the agency concluded that, because states have other mechanisms to build in amounts currently provided through pass-through payments in approvable ways, the fiscal impact in aggregate spending would not be significant. However, transitioning from pass-through payments to other payment structures could result in a redistribution of payments among providers. We are unable to predict what actions the states affected by the rule will take with respect to CMS' policy, including the development of permissible

alternative managed care payment structures to offset the phase out of pass-through payments over the transition period, or what impact those actions might have on our operations, revenues or cash flows.

PRIVATE INSURANCE

Managed Care

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

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

The amount of our managed care net patient revenues during the years ended December 31, 2016, 2015 and 2014 was $11.2 billion, $10.6 billion and $9.3 billion, respectively. Approximately 61% of our managed care net patient revenues for the year ended December 31, 2016 was derived from our top ten managed care payers. National payers generated approximately 44% of our total net managed care revenues. The remainder comes from regional or local payers. At December 31, 2016 and 2015 approximately 66% and 63%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

A managed care contract we had with a national payer expired on September 30, 2016; as a result, our hospitals and other healthcare facilities, as well as our employed physicians, became out-of-network providers with respect to that payer's members. The contract represented approximately 2.9% of our net operating revenues before provision for doubtful accounts for the period subsequent to the sale of our Georgia hospitals on March 31, 2016 to the contract expiration on September 30, 2016. Although there can be no assurance that we will enter into negotiations or reach an agreement with the payer on a new contract, we do not anticipate the expiration of the contract to have a long-term material adverse impact on our business, financial condition or results of operations.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at December 31, 2016, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we

believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefitted from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate recently, and we believe the moderation could continue in future years. In the year ended December 31, 2016, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 77% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

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

SELF-PAY PATIENTS

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

Self-pay accounts pose significant collectability problems. At December 31, 2016 and 2015, approximately 4% and 5%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which is subject to various statutes and regulations regarding consumer protection in areas including finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of this report.

Conifer has performed systematic analyses to focus our attention on the drivers of bad debt expense for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts 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 and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We leverage a statistical-based collections model that aligns our operational capacity to maximize our collections performance. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

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

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The following table shows our estimated costs (based on selected operating expenses) of caring for self-pay patients and charity care patients, as well as revenues attributable to DSH and other supplemental revenues we recognized, in the years ended December 31, 2016, 2015 and 2014.

	Years Ended December 31,		
	2016	2015	2014
Estimated costs for:			
Self-pay patients	$ 644	$ 678	$ 620
Charity care patients	$ 146	$ 191	$ 180
Medicaid DSH and other supplemental revenues	$ 906	$ 888	$ 817

The expansion of health insurance coverage has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage and for persons living in the country who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2016 COMPARED TO THE YEAR ENDED DECEMBER 31, 2015

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2016 and 2015:

	Years Ended December 31,		
	2016	2015	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 16,488	$ 16,741	$ (253)
Other operations	4,582	3,370	1,212
Net operating revenues before provision for doubtful accounts	21,070	20,111	959
Less provision for doubtful accounts	1,449	1,477	(28)
Net operating revenues	**19,621**	**18,634**	987
Equity in earnings of unconsolidated affiliates	**131**	**99**	**32**
Operating expenses:			
Salaries, wages and benefits	9,356	9,011	345
Supplies	3,124	2,963	161
Other operating expenses, net	4,891	4,555	336
Electronic health record incentives	(32)	(72)	40
Depreciation and amortization	850	797	53
Impairment and restructuring charges, and acquisition-related costs	202	318	(116)
Litigation and investigation costs	293	291	2
Gains on sales, consolidation and deconsolidation of facilities	(151)	(186)	35
Operating income	$ 1,219	$ 1,056	$ 163

	Years Ended December 31,		
	2016	2015	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.7 %	0.5 %	0.2 %
Operating expenses:			
Salaries, wages and benefits	47.7 %	48.4 %	(0.7)%
Supplies	15.9 %	15.9 %	— %
Other operating expenses, net	25.0 %	24.4 %	0.6 %
Electronic health record incentives	(0.2)%	(0.4)%	0.2 %
Depreciation and amortization	4.3 %	4.3 %	— %
Impairment and restructuring charges, and acquisition-related costs	1.1 %	1.7 %	(0.6)%
Litigation and investigation costs	1.5 %	1.5 %	— %
Gains on sales, consolidation and deconsolidation of facilities	(0.8)%	(1.0)%	0.2 %
Operating income	**6.2 %**	**5.7 %**	**0.5 %**

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) our Ambulatory Care segment, (4) services provided by our Conifer subsidiary to third parties and (5) our health plans. Revenues from our general hospitals represented approximately 78% and 83% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2016 and 2015, respectively.

Net operating revenues from our other operations were $4.582 billion and $3.370 billion in the years ended December 31, 2016 and 2015, respectively. The increase in net operating revenues from other operations during 2016 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our USPI joint venture and Aspen operations, our health plans and physician practices. Equity in earnings of unconsolidated affiliates were $131 million and $99 million for the years ended December 31, 2016 and 2015, respectively. The increase in equity in earnings of unconsolidated affiliates in the 2016 period compared to the 2015 period primarily related to our USPI joint venture.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 67 hospitals and six health plans operated throughout the years ended December 31, 2016 and 2015. The results of the following facilities are excluded from our same-hospital information: (i) Hi-Desert Medical Center, which we began operating on July 15, 2015, (ii) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (iii) SLUH, which we divested on August 31, 2015, (iv) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (v) DMC Surgery Hospital, which we closed in October 2015, (vi) our two North Carolina hospitals, which we divested effective January 1, 2016, (vii) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (viii) our five Georgia hospitals, which we divested effective April 1, 2016.

Selected Operating Expenses	Years Ended December 31, 2016	2015	Increase (Decrease)
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits	$ 7,121	$ 6,965	2.2 %
Supplies	2,484	2,408	3.2 %
Other operating expenses	3,829	3,466	10.5 %
Total	$ 13,434	$ 12,839	4.6 %
Ambulatory Care			
Salaries, wages and benefits	$ 594	$ 301	97.3 %
Supplies	365	188	94.1 %
Other operating expenses	346	196	76.5 %
Total	$ 1,305	$ 685	90.5 %
Conifer			
Salaries, wages and benefits	$ 959	$ 852	12.6 %
Other operating expenses	335	296	13.2 %
Total	$ 1,294	$ 1,148	12.7 %
Rent/lease expense[1]			
Hospital Operations and other	$ 201	$ 191	5.2 %
Ambulatory Care	74	41	80.5 %
Conifer	18	16	12.5 %
Total	$ 293	$ 248	18.1 %

(1) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported under three segments:

- Hospital Operations and other, which is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals, physician practices and health plans (certain of which are classified as held for sale as described in Note 4 to our Consolidated Financial Statements);
- Ambulatory Care, which is comprised of our USPI joint venture's ambulatory surgery centers, urgent care centers, imaging centers and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; and
- Conifer, which provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems and other entities.

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of our same 67 hospitals and six health plans operated throughout the years ended December 31, 2016 and 2015. The results of the following facilities are excluded from our same-hospital information: (i) Hi-Desert Medical Center, which we began operating on July 15, 2015, (ii) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (iii) SLUH, which we divested on August 31, 2015, (iv) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (v) DMC Surgery Hospital, which we closed in October 2015, (vi) our two North Carolina hospitals, which we divested effective January 1, 2016, (vii) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (viii) our five Georgia hospitals, which we divested effective April 1, 2016.

Admissions, Patient Days and Surgeries	Same-Hospital Continuing Operations Years Ended December 31, 2016	2015	Increase (Decrease)
Number of hospitals (at end of period)	67	67	— [1]
Total admissions	715,502	717,218	(0.2)%
Adjusted patient admissions[2]	1,239,324	1,228,039	0.9 %
Paying admissions (excludes charity and uninsured)	677,361	680,837	(0.5)%
Charity and uninsured admissions	38,141	36,381	4.8 %
Admissions through emergency department	451,785	452,593	(0.2)%
Paying admissions as a percentage of total admissions	94.7 %	94.9 %	(0.2)%[1]
Charity and uninsured admissions as a percentage of total admissions	5.3 %	5.1 %	0.2 %[1]
Emergency department admissions as a percentage of total admissions	63.1 %	63.1 %	— %[1]
Surgeries — inpatient	195,641	196,352	(0.4)%
Surgeries — outpatient	256,301	254,932	0.5 %
Total surgeries	451,942	451,284	0.1 %
Patient days — total	3,269,558	3,286,026	(0.5)%
Adjusted patient days[2]	5,612,240	5,567,041	0.8 %
Average length of stay (days)	4.57	4.58	(0.2)%
Licensed beds (at end of period)	18,118	18,130	(0.1)%
Average licensed beds	18,127	18,217	(0.5)%
Utilization of licensed beds[3]	49.4 %	49.4 %	— %[1]

(1) The change is the difference between 2016 and 2015 amounts shown.
(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Outpatient Visits	Same-Hospital Continuing Operations Years Ended December 31, 2016	2015	Increase (Decrease)
Total visits	7,273,671	7,176,650	1.4 %
Paying visits (excludes charity and uninsured)	6,784,173	6,670,711	1.7 %
Charity and uninsured visits	489,498	505,939	(3.2)%
Emergency department visits	2,560,308	2,520,481	1.6 %
Surgery visits	256,301	254,932	0.5 %
Paying visits as a percentage of total visits	93.3 %	93.0 %	0.3 %[1]
Charity and uninsured visits as a percentage of total visits	6.7 %	7.0 %	(0.3)%[1]

(1) The change is the difference between 2016 and 2015 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2016	2015	Increase (Decrease)
Net operating revenues	$ 14,877	$ 14,148	5.2 %
Revenues from charity and the uninsured	$ 950	$ 879	8.1 %
Net inpatient revenues[1]	$ 9,776	$ 9,334	4.7 %
Net outpatient revenues[1]	$ 5,347	$ 5,103	4.8 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $396 million and $340 million for the years ended December 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $554 million and $539 million for the years ended December 31, 2016 and 2015, respectively.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2016	2015	Increase (Decrease)
Net inpatient revenue per admission	$ 13,663	$ 13,014	5.0 %
Net inpatient revenue per patient day	$ 2,990	$ 2,841	5.2 %
Net outpatient revenue per visit	$ 735	$ 711	3.4 %
Net patient revenue per adjusted patient admission[1]	$ 12,203	$ 11,756	3.8 %
Net patient revenue per adjusted patient day[1]	$ 2,695	$ 2,593	3.9 %

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

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2016	2015	Increase (Decrease)
Provision for doubtful accounts	$ 1,306	$ 1,203	8.6 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	8.1 %	7.8 %	0.3 %[1]

(1) The change is the difference between the 2016 and 2015 amounts shown.

Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits as a percentage of net operating revenues	47.9 %	49.2 %	(1.3)%[1]
Supplies as a percentage of net operating revenues	16.7 %	17.0 %	(0.3)%[1]
Other operating expenses as a percentage of net operating revenues	25.7 %	24.5 %	1.2 %[1]

(1) The change is the difference between the 2016 and 2015 amounts shown.

REVENUES

Same-hospital net operating revenues increased $729 million, or 5.2%, during the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase in same-hospital net operating revenues in the 2016 period is primarily due to volume growth in higher acuity inpatient services, higher outpatient volumes, improved terms of our managed care contracts, incremental net revenues from the California provider fee program of $44 million and an increase in our other operations revenues. Same-hospital net inpatient revenues increased $442 million, or 4.7%, while same-hospital admissions decreased 0.2% in the 2016 period compared to the 2015 period. Same-hospital net inpatient revenue per admission increased 5.0%, primarily due to the improved terms of our managed care contracts and volume growth in higher acuity service lines, in the year ended December 31, 2016. Same-hospital net outpatient revenues increased $244 million, or 4.8%, and same-hospital outpatient visits increased 1.4% in the year ended December 31, 2016 compared to the year ended December 31, 2015. Growth in outpatient revenues and volumes was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program. Same-hospital net outpatient revenue per visit increased 3.4% primarily due to the improved terms of our managed care contracts.

PROVISION FOR DOUBTFUL ACCOUNTS

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.1% and 7.8% for the years ended December 31, 2016 and 2015, respectively. The increases in the 2016 periods compared to the 2015 periods were driven by increases in uninsured revenues and volumes, and higher

patient co-pays and deductibles. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2016 and December 31, 2015:

	December 31, 2016			December 31, 2015		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 404	$ —	$ 404	$ 360	$ —	$ 360
Medicaid	46	—	46	70	—	70
Net cost report settlements payable and valuation allowances	(14)	—	(14)	(42)	—	(42)
Managed care	1,965	175	1,790	1,715	126	1,589
Self-pay uninsured	488	442	46	509	436	73
Self-pay balance after insurance	211	155	56	208	142	66
Estimated future recoveries	141	—	141	144	—	144
Other payers	458	216	242	442	166	276
Total Hospital Operations and other	3,699	988	2,711	3,406	870	2,536
Ambulatory Care	227	43	184	182	17	165
Total discontinued operations	2	—	2	3	—	3
	$ 3,928	$ 1,031	$ 2,897	$ 3,591	$ 887	$ 2,704

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2016, our Hospital Operations and other segment collection rate on self-pay accounts was approximately 26.1%. Our self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2016, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million.

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated Hospital Operations and other segment collection rate from managed care payers was approximately 97.8% at December 31, 2016.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) accounts receivable days outstanding ("AR Days"), and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations and other segment of $2.725 billion and $2.578 billion at December 31, 2016 and 2015, respectively, excluding cost report settlements payable and valuation allowances of $14 million and $42 million at December 31, 2016 and 2015, respectively:

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

	December 31, 2015				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	90 %	65 %	64 %	27 %	62 %
61-120 days	6 %	16 %	16 %	19 %	15 %
121-180 days	2 %	6 %	7 %	11 %	7 %
Over 180 days	2 %	13 %	13 %	43 %	16 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

As of December 31, 2016, we had a cumulative total of patient account assignments to our Conifer subsidiary of approximately $2.9 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 our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medicaid Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. Based on recent trends, approximately 95% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2016 and December 31, 2015 by aging category for the hospitals currently in the program:

	December 31, 2016	December 31, 2015
0-60 days	$ 84	$ 86
61-120 days	13	14
121-180 days	4	7
Over 180 days	4	18
Total	**$ 105**	**$ 125**

SALARIES, WAGES AND BENEFITS

Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased by 130 basis points to 47.9% in the year ended December 31, 2016 compared to the same period in 2015. While same-hospital net operating revenues increased 5.2% in the year ended December 31, 2016 compared to the year ended December 31, 2015, same-hospital salaries, wages and benefits increased by only 2.2% in the year ended December 31, 2016 compared to the 2015 period. The increase in same-hospital salaries, wages and benefits was primarily due to annual merit increases for certain of our employees and increased employee health benefits costs, partially offset lower annual incentive compensation expense. Salaries, wages and benefits expense for the years ended December 31, 2016 and 2015 included stock-based compensation expense of $58 million and $77 million, respectively.

At December 31, 2016, approximately 23% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 34 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six expired contracts covering approximately 8% of our unionized employees and are negotiating renewals under extension agreements. We are also negotiating first contracts at three hospitals and one physician practice covering approximately 5% of our unionized employees where employees recently selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods.

SUPPLIES

Same-hospital supplies expense as a percentage of net operating revenues decreased by 30 basis points to 16.7% in the year ended December 31, 2016 compared to the same period in 2015.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, bulk purchases and operational improvements. The items of current cost reduction focus continue to be cardiac stents and pacemakers, orthopedics and implants, and high-cost pharmaceuticals. We also utilize group-purchasing strategies and supplies-management services in an effort to reduce costs.

OTHER OPERATING EXPENSES, NET

Same-hospital other operating expenses as a percentage of net operating revenues increased by 120 basis points to 25.7% in the year ended December 31, 2016 compared 24.5% to the same period in 2015. The increase in other operating expenses was primarily due to:

- increased costs associated with funding indigent care services by hospitals we operated throughout both periods of $16 million, which costs were substantially offset by additional net patient revenues;
- increased costs of $126 million associated with our health plans due to an increase in covered lives, which costs were partially offset by increased health plan revenues; and
- increased costs of contracted services of $160 million.

Same-hospital malpractice expense in the 2016 period included a favorable adjustment of approximately $4 million due to a 16 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $3 million as a result of a 12 basis point increase in the interest rate in the 2015 period.

Ambulatory Care Segment

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI into our new USPI joint venture, and we acquired Aspen, which operates nine private short-stay surgical hospitals and clinics in the United Kingdom, thereby forming our Ambulatory Care separate reportable business segment. The results of our USPI joint venture and Aspen are included in the financial and statistical information provided only for the period from acquisition to December 31, 2016.

Our USPI joint venture 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. The joint venture 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 bad debt expense); and
- our share of each facility's net income (loss), which is computed by multiplying the facility's net income (loss) times the percentage of each facility's equity interests owned by our USPI joint venture.

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. In many of the facilities our Ambulatory Care segment operates (108 of 323 facilities at December 31, 2016), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method. We control 215 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 us is classified within "net income attributable to noncontrolling interests."

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

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

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

Our Ambulatory Care operating income is driven by the performance of all facilities our USPI joint venture operates and by the joint venture's ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 67% of those facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

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

	Years Ended December 31,	
Ambulatory Care Results of Operations	**2016**	**2015**
Net operating revenues	$ 1,797	$ 959
Equity in earnings of unconsolidated affiliates	$ 122	$ 83
Salaries, wages and benefits	$ 594	$ 301
Supplies	$ 365	$ 188
Other operating expenses, net	$ 346	$ 196

Our Ambulatory Care net operating revenues increased by $838 million, or 87.4%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The growth in revenues was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Salaries, wages and benefits expense increased by $293 million, or 97.3%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Supplies expense increased by $177 million, or 94.1%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Other operating expenses increased by $150 million 76.5%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increases was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Facility Growth

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

Ambulatory Care Facility Growth	Year Ended December 31, 2016
Net revenues	9.6 %
Cases	5.2 %
Net revenue per case	4.2 %

Joint Ventures with Healthcare System Partners

Our USPI joint venture's business model is to jointly own its facilities with local physicians and not-for-profit healthcare systems. Accordingly, as of December 31, 2016, the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities with Healthcare System Partners	Year Ended December 31, 2016
Facilities:	
With a healthcare system partner	177
Without a healthcare system partner	146
Total facilities operated	323
Change from December 31, 2015	
Acquisitions	5
De novo	4
Dispositions/Mergers	(17)
Total decrease in number of facilities operated	(8)

Conifer Segment

Our Conifer subsidiary generated net operating revenues of approximately $1.6 billion and $1.4 billion during the years ended December 31, 2016 and 2015, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the revenue from third-party customers, which is not eliminated in consolidation, is primarily due to new clients.

Salaries, wages and benefits expense for Conifer increased $107 million, or 12.6%, in the year ended December 31, 2016 compared to the year ended December 31, 2015 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to new clients. Conifer typically incurs start-up and other transition costs during the initial term of new client contracts.

Other operating expenses for Conifer increased $39 million, or 13.2%, in the year ended December 31, 2016 compared to the year ended December 31, 2015 due to the growth in Conifer's business primarily attributable to new clients. Conifer typically incurs start-up and other transition costs during the initial term of new client contracts.

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

Conifer's master service agreement with Tenet expires in December 2018. Prior to the expiration, we will undertake a new fair market value analysis with respect to the pricing of these services and use that analysis in our negotiation of renewal contracts. As a result, it is possible that the pricing under the renegotiated agreements may be different from the current agreements. Any changes in the price or other terms of the contract could have a material impact on our Conifer segment's results of operations. Conifer's contract with Tenet represented approximately 41% of the net operating revenues Conifer recognized in the year ended December 31, 2016.

Consolidated

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $202 million. This amount included impairment charges of approximately $54 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at four of our hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, these hospitals are at risk of future impairments, particularly if we spend significant amounts of capital at the hospitals without generating a corresponding increase in the hospitals' fair value or if the fair value of the hospitals' real estate or equipment declines. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $163 million as of December 31, 2016 after recording the impairment charges. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract related intangibles and capitalized software costs not associated with the hospitals described above. Of the total impairment charges recognized for the year ended December 31, 2016, $76 million related to our Hospital Operations and other segment, $8 million related to our Ambulatory Care segment, and $3 million related to our Conifer segment. We also recorded $35 million of employee severance costs, $14 million of restructuring costs, $14 million of contract and lease termination fees, and $52 million in acquisition-related costs, which include $20 million of transaction costs and $32 million of acquisition integration costs.

During the year ended December 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $318 million, including $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 5. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million of impairment charges related to investments. We also recorded $25 million of employee severance costs, $6 million of restructuring costs, $19 million of contract and lease termination fees, and $100 million in acquisition-related costs, which include $55 million of transaction costs and $45 million of acquisition integration costs.

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

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the years ended December 31, 2016 and 2015 were $293 million and $291 million, respectively. Of these amounts, $278 million and $219 million for the years ended December 31, 2016 and 2015, respectively, were attributable to accruals for the Clinica de la Mama matter, which is further described in Note 14 to our Consolidated Financial Statements.

GAINS ON SALES, CONSOLIDATION AND DECONSOLIDATION OF FACILITIES

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

During the year ended December 31, 2015, we recorded gains on sales, consolidation and deconsolidation of facilities of approximately $186 million, comprised of a $151 million gain on deconsolidation due to our joint venture with Baylor Scott & White Health ("BSW"), a $3 million gain from the sale of our North Carolina facilities and $32 million of gains related to the consolidation and deconsolidation of certain businesses of our USPI joint venture due to ownership changes.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2016 was $979 million compared to $912 million for the year ended December 31, 2015, primarily due to increased borrowings related to our 2015 acquisitions.

INCOME TAX EXPENSE

During the year ended December 31, 2016, we recorded income tax expense of $67 million in continuing operations on pre-tax income of $248 million, compared to income tax expense of $68 million on pre-tax income of $144 million during the year ended December 31, 2015. The reconciliation between the amount of recorded income tax expense (benefit) and the amount calculated at the statutory federal tax rate is shown below.

	Years Ended December 31,	
	2016	2015
Tax expense at statutory federal rate of 35%	$ 87	$ 50
State income taxes, net of federal income tax benefit	16	18
Expired state net operating losses, net of federal income tax benefit	35	11
Tax attributable to noncontrolling interests	(106)	(59)
Nondeductible goodwill	29	22
Nontaxable gains	(11)	(11)
Nondeductible litigation costs	37	44
Nondeductible acquisition costs	1	4
Nondeductible health insurance provider fee	2	2
Changes in valuation allowance	(25)	4
Change in tax contingency reserves, including interest	(9)	7
Amendment of prior-year tax returns	—	(17)
Prior-year provision to return adjustments and other changes in deferred taxes	12	(12)
Other items	(1)	5
	$ 67	$ 68

NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS

Net income attributable to noncontrolling interests was $368 million for the year ended December 31, 2016 compared to $218 million for the year ended December 31, 2015. Net income attributable to noncontrolling interests for

the year ended December 31, 2016 was comprised of $31 million related to our Hospital Operations and other segment, $285 million related to our Ambulatory Care segment and $52 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $65 million was related to the minority interest in our USPI joint venture.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

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

"Adjusted EBITDA" is a non-GAAP measure defined by the Company as net income available (loss attributable) to Tenet Healthcare Corporation common shareholders before (1) the cumulative effect of changes in accounting principle, (2) net loss (income) attributable to noncontrolling interests, (3) income (loss) from discontinued operations, (4) income tax benefit (expense), (5) investment earnings (losses), (6) gain (loss) from early extinguishment of debt, (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, and (11) depreciation and amortization. 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 on the Company's financial performance. Investors, analysts, Company management and the Company's Board of Directors utilize this non-GAAP measure, in addition to GAAP measures, to track the Company's financial and operating performance and compare the Company's performance to its 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 of these measures to evaluate management's performance for the purpose of determining incentive compensation. Additional information regarding the purpose and utility of specific non-GAAP measures used by the Company is set forth below. 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 other GAAP and 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. This non-GAAP measure 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 table below shows the reconciliation of Adjusted EBITDA to net income available (loss attributable) to Tenet Healthcare Corporation common shareholders (the most comparable GAAP term) for the years ended December 31, 2016 and 2015:

	Years Ended December 31,	
	2016	2015
Net loss attributable to Tenet Healthcare Corporation common shareholders	$ (192)	$ (140)
Less: Net income attributable to noncontrolling interests	(368)	(218)
Net income (loss) from discontinued operations, net of tax	(5)	2
Net income from continuing operations	181	76
Income tax expense	(67)	(68)
Investment earnings (losses)	8	1
Loss from early extinguishment of debt	—	(1)
Interest expense	(979)	(912)
Operating income	1,219	1,056
Litigation and investigation costs	(293)	(291)
Gains on sales, consolidation and deconsolidation of facilities	151	186
Impairment and restructuring charges, and acquisition-related costs	(202)	(318)
Depreciation and amortization	(850)	(797)
Adjusted EBITDA	$ 2,413	$ 2,276
Net operating revenues	$ 19,621	$ 18,634
Net loss from continuing operations as a % of operating revenues	(1.0)%	(0.8)%
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	12.3 %	12.2 %

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2015 COMPARED TO THE YEAR ENDED DECEMBER 31, 2014

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2015 and 2014:

	Years Ended December 31,		
	2015	2014	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 16,741	$ 15,518	$ 1,223
Other operations	3,370	2,390	980
Net operating revenues before provision for doubtful accounts	20,111	17,908	2,203
Less provision for doubtful accounts	1,477	1,305	172
Net operating revenues	**18,634**	**16,603**	**2,031**
Equity in earnings of unconsolidated affiliates	**99**	**12**	**87**
Operating expenses:			
Salaries, wages and benefits	9,011	8,023	988
Supplies	2,963	2,630	333
Other operating expenses, net	4,555	4,114	441
Electronic health record incentives	(72)	(104)	32
Depreciation and amortization	797	849	(52)
Impairment and restructuring charges, and acquisition-related costs	318	153	165
Litigation and investigation costs	291	25	266
Gains on sales, consolidation and deconsolidation of facilities	(186)	—	(186)
Operating income	**$ 1,056**	**$ 925**	**$ 131**

	Years Ended December 31,		
	2015	2014	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.5 %	0.1 %	0.4 %
Operating expenses:			
Salaries, wages and benefits	48.4 %	48.3 %	0.1 %
Supplies	15.9 %	15.8 %	0.1 %
Other operating expenses, net	24.4 %	24.8 %	(0.4)%
Electronic health record incentives	(0.4)%	(0.6)%	0.2 %
Depreciation and amortization	4.3 %	5.1 %	(0.8)%
Impairment and restructuring charges, and acquisition-related costs	1.7 %	0.9 %	0.8 %
Litigation and investigation costs	1.5 %	0.2 %	1.3 %
Gains on sales, consolidation and deconsolidation of facilities	(1.0)%	— %	(1.0)%
Operating income	**5.7 %**	**5.6 %**	**0.1 %**

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) our Ambulatory Care segment, (4) services provided by our Conifer subsidiary to third parties and (5) our health plans. Revenues from our general hospitals represented approximately 83% and 87% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2015 and 2014, respectively.

Net operating revenues from our other operations were $3.370 billion and $2.390 billion in the years ended December 31, 2015 and 2014, respectively. The increase in net operating revenues from other operations during 2015 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our USPI joint venture and Aspen acquisition, our health plans and physician practices. Equity in earnings of unconsolidated affiliates were $99 million and $12 million for the years ended December 31, 2015 and 2014, respectively. The increase in equity in earnings of unconsolidated affiliates in the 2015 period compared to the 2014 period primarily relates to our USPI joint venture.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 75 hospitals and six health plans operated throughout the years ended December 31, 2015 and 2014. The results of TRMC, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, Emanuel Medical Center, which we acquired on August 1, 2014, Hi-Desert Medical Center, which we began operating on July 15, 2015, our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, SLUH, which we sold on August 31, 2015, our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and DMC Surgery Hospital, which we closed in October 2015, are excluded. Certain previously reported information has been reclassified to conform to the current-year presentation, primarily related to the sale of SLUH and our contribution of freestanding ambulatory surgery and imaging center assets to the USPI joint venture. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

	Same Hospital Continuing Operations Years Ended December 31,		
Selected Operating Expenses	2015	2014	Increase (Decrease)
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits	$ 7,438	$ 7,005	6.2 %
Supplies	2,590	2,459	5.3 %
Other operating expenses	3,779	3,569	5.9 %
Total	$ 13,807	$ 13,033	5.9 %
Salaries, wages and benefits per adjusted patient admission[1]	$ 5,579	$ 5,433	2.7 %
Supplies per adjusted patient admission[1]	1,943	1,889	2.9 %
Other operating expenses per adjusted patient admission[1]	2,856	2,774	3.0 %
Total per adjusted patient admission	$ 10,378	$ 10,096	2.8 %
Ambulatory Care			
Salaries, wages and benefits	$ 301	$ 87	246.0 %
Supplies	188	61	208.2 %
Other operating expenses	196	74	164.9 %
Total	$ 685	$ 222	208.6 %
Conifer			
Salaries, wages and benefits	$ 852	$ 727	17.2 %
Other operating expenses	296	263	12.5 %
Total	$ 1,148	$ 990	16.0 %
Rent/lease expense[2]			
Hospital Operations and other	$ 214	$ 191	12.0 %
Conifer	16	21	(23.8)%
Ambulatory Care	41	22	86.4 %
Total	$ 271	$ 234	15.8 %

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

(2) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported under three segments: Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, urgent care facilities, freestanding emergency departments, physician practices and health plans; Ambulatory Care, which is comprised of our freestanding ambulatory surgery and imaging centers, short-stay surgical facilities and Aspen's hospitals and clinics; and Conifer, which operates revenue cycle management and patient communication and engagement services businesses.

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of our same 75 hospitals and six health plans operated throughout the years ended December 31, 2015 and 2014. The results of TRMC, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, Emanuel Medical Center, which we acquired on August 1, 2014, Hi-Desert Medical Center, which we began operating on July 15, 2015, our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, SLUH, which we sold on August 31, 2015, our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and DMC Surgery Hospital, which we closed in October 2015, are excluded. Certain previously reported information has been reclassified to conform to the current-year presentation, primarily related to the sale of SLUH and our contribution of freestanding ambulatory surgery and imaging center assets to the USPI joint venture. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

	Same-Hospital Continuing Operations Years Ended December 31,		
Admissions, Patient Days and Surgeries	2015	2014	Increase (Decrease)
Total admissions	774,480	765,951	1.1 %
Adjusted patient admissions[1]	1,333,227	1,301,936	2.4 %
Paying admissions (excludes charity and uninsured)	733,155	722,455	1.5 %
Charity and uninsured admissions	41,325	43,496	(5.0)%
Admissions through emergency department	489,401	479,805	2.0 %
Paying admissions as a percentage of total admissions	94.7 %	94.3 %	0.4 %[2]
Charity and uninsured admissions as a percentage of total admissions	5.3 %	5.7 %	(0.4)%[2]
Emergency department admissions as a percentage of total admissions	63.2 %	62.6 %	0.6 %[2]
Surgeries — inpatient	211,063	209,385	0.8 %
Surgeries — outpatient	276,890	273,248	1.3 %
Total surgeries	487,953	482,633	1.1 %
Patient days — total	3,573,155	3,566,694	0.2 %
Adjusted patient days[1]	6,083,749	5,993,861	1.5 %
Average length of stay (days)	4.61	4.66	(1.1)%
Number of hospitals (at end of period)	75	75	—[2]
Licensed beds (at end of period)	19,882	19,984	(0.5)%
Average licensed beds	19,969	19,905	0.3 %
Utilization of licensed beds[3]	49.0 %	49.1 %	(0.1)%[2]

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between 2015 and 2014 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Outpatient Visits	Same-Hospital Continuing Operations Years Ended December 31, 2015	2014	Increase (Decrease)
Total visits	7,831,785	7,496,243	4.5 %
Paying visits (excludes charity and uninsured)	7,213,214	6,859,531	5.2 %
Charity and uninsured visits	618,571	636,712	(2.8)%
Emergency department visits	2,816,943	2,738,233	2.9 %
Surgery visits	276,890	273,248	1.3 %
Paying visits as a percentage of total visits	92.1 %	91.5 %	0.6 %[1]
Charity and uninsured visits as a percentage of total visits	7.9 %	8.5 %	(0.6)%[1]

(1) The change is the difference between 2015 and 2014 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2015	2014	Increase (Decrease)
Net operating revenues	$ 15,334	$ 14,553	5.4 %
Revenues from charity and the uninsured	$ 992	$ 1,025	(3.2)%
Net inpatient revenues[1]	$ 10,079	$ 9,615	4.8 %
Net outpatient revenues[1]	$ 5,630	$ 5,271	6.8 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $374 million and $381 million for the years ended December 31, 2015 and 2014, respectively. Net outpatient revenues include self-pay revenues of $618 million and $644 million for the years ended December 31, 2015 and 2014, respectively.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2015	2014	Increase (Decrease)
Net inpatient revenue per admission	$ 13,014	$ 12,553	3.7 %
Net inpatient revenue per patient day	$ 2,821	$ 2,696	4.6 %
Net outpatient revenue per visit	$ 719	$ 703	2.3 %
Net patient revenue per adjusted patient admission[1]	$ 11,783	$ 11,434	3.1 %
Net patient revenue per adjusted patient day[1]	$ 2,582	$ 2,484	3.9 %

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

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2015	2014	Increase (Decrease)
Provision for doubtful accounts	$ 1,375	$ 1,250	10.0 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	8.2 %	8.0 %	0.2 %[1]

(1) The change is the difference between the 2015 and 2014 amounts shown.

REVENUES

Same-hospital net operating revenues increased $781 million, or 5.4%, during the year ended December 31, 2015 compared to the year ended December 31, 2014. The increase in same-hospital net operating revenues in the 2015 period is primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts, incremental net revenues from the California provider fee program of $15 million and an increase in our other operations revenues. For the years ended December 31, 2015 and 2014, our net operating revenues attributable to

Medicaid DSH and other supplemental revenues were approximately $840 million and $775 million, respectively. Same-hospital net inpatient revenues increased $464 million, or 4.8%, and same-hospital admissions increased 1.1% in the 2015 period compared to the 2014 period. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy. Same-hospital net inpatient revenue per admission increased 3.7%, primarily due to the improved terms of our managed care contracts and volume growth in higher acuity service lines, in the year ended December 31, 2015. Same-hospital net outpatient revenues increased $359 million, or 6.8%, and same-hospital outpatient visits increased 4.5% in the year ended December 31, 2015 compared to the year ended December 31, 2014. Growth in outpatient revenues and volumes was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program. Same-hospital net outpatient revenue per visit increased 2.3% primarily due to the improved terms of our managed care contracts.

PROVISION FOR DOUBTFUL ACCOUNTS

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.2% and 8.0% for the years ended December 31, 2015 and 2014, respectively. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2015 and December 31, 2014:

	December 31, 2015			December 31, 2014		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 360	$ —	$ 360	$ 323	$ —	$ 323
Medicaid	70	—	70	153	—	153
Net cost report settlements payable and valuation allowances	(42)	—	(42)	(51)	—	(51)
Managed care	1,715	126	1,589	1,528	99	1,429
Self-pay uninsured	509	436	73	578	482	96
Self-pay balance after insurance	208	142	66	210	133	77
Estimated future recoveries from accounts assigned to our Conifer subsidiary	144	—	144	125	—	125
Other payers	442	166	276	337	125	212
Total Hospital Operations and other	3,406	870	2,536	3,203	839	2,364
Ambulatory Care	182	17	165	49	12	37
Total discontinued operations	3	—	3	4	1	3
	$ 3,591	**$ 887**	**$ 2,704**	**$ 3,256**	**$ 852**	**$ 2,404**

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2015, our collection rate on self-pay accounts was approximately 29.7%. Our self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2015, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $10 million. Our estimated collection rate from managed care payers was approximately 98.0% at December 31, 2015.

The following tables present the approximate aging by payer of our net accounts receivable from Hospital Operations and other segment of $2.578 billion and $2.415 billion at December 31, 2015 and 2014, respectively, excluding cost report settlements payable and valuation allowances of $42 million and $51 million at December 31, 2015 and 2014, respectively:

	December 31, 2015				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	90 %	65 %	64 %	27 %	62 %
61-120 days	6 %	16 %	16 %	19 %	15 %
121-180 days	2 %	6 %	7 %	11 %	7 %
Over 180 days	2 %	13 %	13 %	43 %	16 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

	December 31, 2014				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	81 %	44 %	66 %	29 %	61 %
61-120 days	9 %	22 %	16 %	19 %	16 %
121-180 days	4 %	12 %	7 %	11 %	7 %
Over 180 days	6 %	22 %	11 %	41 %	16 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

Our AR Days from continuing operations were 49.5 days at both December 31, 2015 and December 31, 2014, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2015, we had a cumulative total of patient account assignments to our Conifer subsidiary of approximately $2.7 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2015 and December 31, 2014 by aging category:

	December 31, 2015	December 31, 2014
0-60 days	$ 86	$ 85
61-120 days	14	20
121-180 days	7	10
Over 180 days	18	16
Total	**$ 125**	**$ 131**

SALARIES, WAGES AND BENEFITS

Same-hospital salaries, wages and benefits per adjusted patient admission increased by 2.7% in the year ended December 31, 2015 compared to the same period in 2014. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, and increased employee health benefits and incentive compensation costs. Salaries, wages and benefits expense for the year ended December 31, 2015 and 2014 included stock-based compensation expense of $77 million and $51 million, respectively.

SUPPLIES

Supplies expense per adjusted patient admission for our Hospital Operations and other segment increased by 2.9% in the year ended December 31, 2015 compared to the same period in 2014. The increase in supplies expense per adjusted patient admission was primarily attributable to higher costs for pharmaceuticals and cardiology supplies, as well as volume growth in our supply-intensive surgical services, partially offset by lower implant costs.

OTHER OPERATING EXPENSES, NET

Same-hospital other operating expenses per adjusted patient admission increased by 3.0% in the year ended December 31, 2015 compared to the same period in 2014. Other operating expenses on a per adjusted admission basis were impacted by:

- higher same-hospital malpractice expense of $46 million;
- increased information systems maintenance contract costs of $45 million;
- additional costs related to a greater number of employed and contracted physicians for hospitals we operated throughout both periods of $56 million; and
- increased costs associated with funding indigent care services by the Texas hospitals we operated throughout both periods of $9 million, which costs were substantially offset by additional net patient revenues.

Same-hospital malpractice expense was higher in the year ended December 31, 2015 compared to the year ended December 31, 2014 due to incremental patient volumes and unfavorable adjustments to settle various cases to mitigate the risk of protracted litigation, partially offset by a favorable adjustment in the 2015 period of approximately $3 million due to a 12 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of approximately $7 million as a result of a 48 basis point decrease in the interest rate in the 2014 period.

Ambulatory Care Segment

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI into our new USPI joint venture, and we acquired Aspen, which operates nine private short-stay surgical hospitals and clinics in the United Kingdom, thereby forming our new Ambulatory Care separate reportable business segment. The results of our USPI joint venture and Aspen are included in the financial and statistical information provided only for the period from acquisition to December 31, 2015. Information that is reported on a same-facility basis relates to the freestanding ambulatory surgery and diagnostic imaging centers that we operated throughout the year ended December 31, 2015 and 2014 and were contributed to the USPI joint venture.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

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

	Years Ended December 31,	
Ambulatory Care Results of Operations	2015	2014
Net operating revenues	$ 959	$ 320
Equity in earnings of unconsolidated affiliates	$ 83	$ —
Salaries, wages and benefits	$ 301	$ 87
Supplies	$ 188	$ 61
Other operating expenses, net	$ 196	$ 74

Our Ambulatory Care net operating revenues increased by $639 million, or 199.7%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. The growth in revenues was driven by increases from acquisitions of $603 million, and increases from our same-facility operations of $36 million, for the year ended December 31, 2015 compared to the year ended December 31, 2014.

Salaries, wages and benefits expense increased by $214 million, or 246.0%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. These increases were driven by increases in salaries, wages and benefits expense from acquisitions of $208 million, and increases in our same-facility salaries, wages and benefits expense of $6 million, for the year ended December 31, 2015 compared by the year ended December 31, 2014.

Supplies expense increased by $127 million, or 208.2%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. These increases were driven by increases in supplies expense from acquisitions of $117 million, and increases in our same-facility supplies expense of $10 million, for the year ended December 31, 2015 compared to the year ended December 31, 2014.

Other operating expenses increased by $122 million, or 164.9%, for the year ended December 31, 2015 compared to the year ended December 31, 2014. These increases were driven by increases in other operating expenses from acquisitions of $113 million, and increases in our same-facility supplies expense of $7 million, for the year ended December 31, 2015 compared to the year ended December 31, 2014.

Facility Growth

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

Ambulatory Care Facility Growth	Year Ended December 31, 2015
Net revenue	11.7 %
Cases	7.9 %
Net revenue per case	3.6 %

Joint Ventures with Healthcare System Partners

During the three months ended June 30, 2015, we established our new Ambulatory Care segment as a result of our joint venture with USPI and our purchase of Aspen. USPI's business model is to jointly own its facilities with local physicians and not-for-profit healthcare systems. Accordingly, as of December 31, 2015, the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities with Healthcare System Partners	Year Ended December 31, 2015
Facilities:	
With a healthcare system partner	181
Without a healthcare system partner	152
Total facilities operated	333
Change from December 31, 2014	
Acquired through USPI joint venture and Aspen acquisition	227
Other acquisitions	47
Dispositions/Mergers	(3)
Total increase in number of facilities operated	271

Conifer Segment

Our Conifer subsidiary generated net operating revenues of $1.4 billion and $1.2 billion during the years ended December 31, 2015 and 2014, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the revenue from third-party customers, which is not eliminated in consolidation, is primarily due to new clients, service growth and Conifer's acquisition of SPi Healthcare in the fourth quarter of 2014.

Salaries, wages and benefits expense for Conifer increased $125 million, or 17.2%, in the year ended December 31, 2015 compared to the year ended December 31, 2014 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to Conifer's acquisition of SPi Healthcare and expanded services to CHI.

Other operating expenses for Conifer increased $33 million, or 12.5%, in the year ended December 31, 2015 compared to the year ended December 31, 2014 due to the growth in Conifer's business primarily attributable to Conifer's acquisition of SPi Healthcare and expanded services to CHI.

Consolidated

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $318 million, including $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 4. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, these hospitals are at risk of future impairments, particularly if we spend significant amounts of capital at the hospitals without generating a corresponding increase in the hospitals' fair value or if the fair value of the hospitals' real estate or equipment declines. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million related to investments. We also recorded $25 million of employee severance costs, $6 million of restructuring costs, $19 million of contract and lease termination fees, and $100 million in acquisition-related costs, which include $55 million of transaction costs and $45 million of acquisition integration costs.

During the year ended December 31, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $153 million. This amount included a $20 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets

and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment declines. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $23 million as of December 31, 2014 after recording the impairment charge. We also recorded $16 million of employee severance costs, $19 million of contract and lease termination fees, $3 million of restructuring costs, and $95 million in acquisition-related costs, which include $16 million of transaction costs and $79 million of acquisition integration charges.

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the years ended December 31, 2015 and 2014 were $291 million and $25 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews described in Note 14 to our Consolidated Financial Statements.

GAINS ON SALES, CONSOLIDATION AND DECONSOLIDATION OF FACILITIES

During the year ended December 31, 2015, we recorded gains on sales, consolidation and deconsolidation of facilities of approximately $186 million, comprised of a $151 million gain on deconsolidation due to our joint venture with BSW, a $3 million gain from the sale of our North Carolina facilities and $32 million of gains related to the consolidation and deconsolidation of certain businesses of our USPI joint venture due to ownership changes.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2015 was $912 million compared to $754 million for the year ended December 31, 2014, primarily due to increased borrowings relating to our recent acquisitions and our $254 million payment to acquire the remaining 49% noncontrolling interest of our Valley Baptist Health System in South Texas.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9¼% senior unsecured notes due 2015 that we redeemed in the period, as well as the write-off of associated unamortized note discounts and issuance costs. During the year ended December 31, 2015, we recorded a loss of approximately $1 million.

INCOME TAX EXPENSE

During the year ended December 31, 2015, we recorded income tax expense of $68 million compared to $49 million during the year ended December 31, 2014.

NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS

Net income attributable to noncontrolling interests was $218 million for the year ended December 31, 2015 compared to $64 million for the year ended December 31, 2014. Net income attributable to noncontrolling interests for the year ended December 31, 2015 was comprised of $31 million related to our Hospital Operations and other segment, $138 million related to our Ambulatory Care segment and $49 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $50 million was related to the Welsh, Carson, Anderson & Stowe minority interest in our USPI joint venture. The portion related to our Conifer segment is due to CHI's ownership interest in Conifer's principal operating subsidiary, Conifer Health Solutions, LLC.

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Our obligations to make future cash payments under contracts, such as debt and lease agreements, and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, are summarized in the table below, all as of December 31, 2016:

	Total	Years Ended December 31,					Later Years
		2017	2018	2019	2020	2021	
				(In Millions)			
Long-term debt[1]	$ 19,163	$ 902	$ 1,966	$ 2,419	$ 4,977	$ 2,418	$ 6,481
Capital lease obligations[1]	1,005	216	101	73	49	35	531
Long-term non-cancelable operating leases	1,216	215	182	156	125	102	436
Standby letters of credit	110	105	5	—	—	—	—
Guarantees[2]	95	72	21	2	—	—	—
Asset retirement obligations	236	—	—	—	—	—	236
Academic affiliation agreements[3]	82	54	19	9	—	—	—
Tax liabilities	25	—	—	—	—	—	25
Defined benefit plan obligations	690	62	21	22	22	22	541
Construction and capital improvements	5	5	—	—	—	—	—
Information technology contract services	1,193	259	248	240	244	181	21
Purchase orders	354	354	—	—	—	—	—
Total[4]	$ 24,174	$ 2,244	$ 2,563	$ 2,921	$ 5,417	$ 2,758	$ 8,271

(1) Includes interest through maturity date/lease termination.
(2) Includes minimum revenue guarantees, primarily related to physicians under relocation agreements and physician groups that provide services at our hospitals, and operating lease guarantees.
(3) These agreements contain various rights and termination provisions.
(4) Professional liability and workers' compensation reserves, and our obligations under the Put/Call Agreement and the Baylor Put/Call Agreement, as defined in Note 15 to our Consolidated Financial Statements, have been excluded from the table. At December 31, 2016, the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were approximately $181 million and $613 million, respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were approximately $50 million and $204 million, respectively. Redeemable noncontrolling interests in our USPI joint venture that are subject to the Put/Call Agreement and the Baylor Put/Call Agreement totaled approximately $1.25 billion at December 31, 2016. In January 2017, subsidiaries of Welsh, Carson, Anderson & Stowe delivered a put notice for the minimum number of shares they are required to put to us in 2017 according to the Put/Call Agreement. The estimated amount we will pay to repurchase these shares is between $159 million and $170 million.

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

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2016:

- In December 2016, we sold $750 million aggregate amount of 7½% senior secured second lien notes, which will mature on January 1, 2022. We will pay interest on the 7½% senior secured second lien notes semi-annually in arrears on January 1 and July 1 of each year, commencing on July 1, 2017. The net proceeds of the notes were used, after payment of fees and expenses, to repay indebtedness outstanding under our senior secured revolving credit facility and for general corporate purposes.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our cash and our operating

results. At December 31, 2016, 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 6.03x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including the use of our Credit Agreement as a source of liquidity and acquisitions that involve the assumption of long-term debt. We intend to manage this ratio by following our business plan, managing our cost structure, possible assets divestitures and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections of Part I of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable statutes and regulations), equipment and information systems additions and replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements, as well as commitments to make capital expenditures in connection with the acquisition of businesses. Capital expenditures were $875 million, $842 million and $933 million in the years ended December 31, 2016, 2015 and 2014, respectively. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2017 will total approximately $700 million to $750 million, including $179 million that was accrued as a liability at December 31, 2016. Our budgeted 2017 capital expenditures include approximately $3 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree.

During the year ended December 31, 2016, we completed the transaction that allowed us to consolidate five microhospitals that were previously recorded as equity method investments. We also acquired majority interests in 28 ambulatory surgery centers (all of which are owned by our USPI joint venture) and various physician practices. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $117 million.

Interest payments, net of capitalized interest, were $932 million, $859 million and $726 million in the years ended December 31, 2016, 2015 and 2014, respectively. For the year ending December 31, 2017, we expect annual interest expense to increase by $50 million to $55 million from 2016 due primarily to the issuance of the 7 1/2% senior secured second lien notes in December 2016.

Income tax payments, net of tax refunds, were approximately $33 million in the year ended December 31, 2016 compared to approximately $7 million in the year ended December 31, 2015. At December 31, 2016, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax expiring in 2025 to 2034, (2) approximately $30 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $24 million expiring in 2023 through 2036, and (4) state NOL carryforwards of $3.0 billion expiring in 2017 through 2036 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $19 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs (see Note 2), the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

Periodic examinations of our tax returns by the Internal Revenue Service ("IRS") or other taxing authorities could result in the payment of additional taxes. The IRS has completed audits of our tax returns for all tax years ended on or before December 31, 2007, and of Vanguard's tax returns for fiscal years ending on or before October 1, 2013. All disputed issues with respect to these audits have been resolved, and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007 and Vanguard's tax returns for fiscal years ended after October 1, 2013 remain subject to examination by the IRS. USPI tax returns for years ended after December 31, 2011 remain subject to audit.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2016 was primarily derived from net cash provided by operating activities, cash on hand, issuance of long-term debt and borrowings under our revolving credit facility. We had approximately $716 million of cash and cash equivalents on hand at December 31, 2016 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $998 million based on our borrowing base calculation as of December 31, 2016.

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

Net cash provided by operating activities was $558 million in the year ended December 31, 2016 compared to $1.026 billion in the year ended December 31, 2015. Key positive and negative factors contributing to the change between the 2016 and 2015 periods include the following:

- Increased income from continuing operations before income taxes of $137 million, excluding investment earnings (losses), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the year ended December 31, 2016 compared to the year ended December 31, 2015;

- An increase of $491 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;

- Approximately $84 million of additional net cash proceeds in the 2016 period related to supplemental Medicaid programs in California and Texas;

- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $18 million and $9 million, respectively, in the year ended December 31, 2016 compared to the year ended December 31, 2015;

- Higher interest payments of $73 million.

- A $15 million decrease in cash used in discontinued operations; and

- The timing of other working capital items.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash including by means of the sale of underutilized or inefficient assets.

Net cash used in investing activities was $430 million for the year ended December 31, 2016 compared to $1.317 billion for the year ended December 31, 2015. The primary reason for the decrease was due to acquisitions of businesses and joint venture interests of only $117 million in the 2016 period primarily related to freestanding outpatient facilities compared to $940 million in the 2015 period when we purchased Aspen and formed our USPI, Carondelet Health Network, and Baptist Health System, Inc. joint ventures. In the 2016 period, we generated $573 million of proceeds from the sale of our Georgia facilities compared to $549 million of proceeds in the 2015 period from: (i) the sale of SLUH; (ii) the sale of our hospitals, physician practices and related assets in North Carolina; and (iii) our joint venture with BSW. Capital expenditures were $875 million and $842 million in the years ended December 31, 2016 and 2015, respectively.

Net cash used in financing activities to purchase noncontrolling interests was $186 million and $268 million for the years ended December 31, 2016 and 2015, respectively. The 2016 amount included $127 million to increase our ownership interest in our USPI joint venture from 50.1% to approximately 56.3% under our Put/Call Agreement as

defined in Note 15 to our Consolidated Financial Statements. The 2015 amount included $254 million to acquire the remaining 49% noncontrolling interest of our Valley Baptist Health System in South Texas.

In November 2015, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2016. Pursuant to the share repurchase program, we paid approximately $40 million to repurchase a total of 1,242,806 shares during the period from the commencement of the program through December 31, 2015. There were no purchases under the program during the year ended December 31, 2016.

We record our investments that are available-for-sale at fair market value. As shown in Note 18 to the Consolidated Financial Statements, the majority of our investments are valued based on quoted market prices or other observable inputs. We have no investments that we expect will be negatively affected by the current economic conditions such that they will materially impact our financial condition, results of operations or cash flows.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

We have a senior secured revolving credit facility (as amended, "Credit Agreement"), which provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of December 4, 2020, are guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and are secured by a first priority lien on the accounts receivable owned by us and the subsidiary guarantors. At December 31, 2016, we were in compliance with all covenants and conditions in our Credit Agreement. At December 31, 2016, we had no cash borrowings outstanding under the revolving credit facility, and we had approximately $2 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $998 million was available for borrowing under the revolving credit facility at December 31, 2016.

We have a letter of credit facility (as amended, "LC Facility") that provides for the issuance of standby and documentary letters of credit, from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). Obligations under the LC Facility are guaranteed by 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. On September 15, 2016, we entered into an amendment to our existing letter of credit facility agreement in order to, among other things, (i) extend the scheduled maturity date of the LC Facility to March 7, 2021, and reduce certain margins and fees payable under the LC Facility. We are in compliance with all covenants and conditions in our LC Facility. At December 31, 2016, we had approximately $108 million of standby letters of credit outstanding under the LC Facility.

In December 2016, we sold $750 million aggregate amount of 7½% senior secured notes, which will mature on January 1, 2022. We will pay interest on the 7½% senior secured second lien notes semi-annually in arrears on January 1 and July 1 of each year, commencing on July 1, 2017. The net proceeds of the notes were used, after payment of fees and expenses, to repay indebtedness outstanding under our senior secured revolving credit facility and for general corporate purposes.

In June 2015, we sold $900 million aggregate principal amount of floating rate senior secured notes, which will mature on June 15, 2020, and assumed $1.9 billion aggregate principal amount of 6¾% senior unsecured notes, which will mature on June 15, 2023, issued by THC Escrow Corporation II. We pay interest on the floating rate senior secured notes quarterly in arrears on March 15, June 15, September 15 and December 15 of each year, which payments commenced on September 15, 2015. The 6¾% senior unsecured notes accrue interest at a rate per annum, reset quarterly, equal to LIBOR plus 3½%. We pay interest on the 6¾% senior unsecured notes semi-annually in arrears on June 15 and December 15 of each year, which payments commenced on December 15, 2015. The proceeds from the sale of these notes were used to repay borrowings outstanding under a $400 million secured term loan facility and our Credit Agreement, as well as to refinance the debt of USPI and to pay the cash consideration in respect of our USPI joint venture and Aspen acquisition.

In September 2014, we sold $500 million aggregate principal amount of 5½% senior unsecured notes, which will mature on March 1, 2019. We pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on March 1, 2015. The proceeds from the sale of the notes were used for general

corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior unsecured notes, which will mature on March 1, 2019. We pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 9 1/4% senior unsecured notes due 2015 in July 2014. The net proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement.

For additional information regarding our long-term debt and capital lease obligations, see Note 6 to the accompanying Consolidated Financial Statements.

LIQUIDITY

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

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

Long-term liquidity for debt service and other purposes will be dependent on the amount of cash provided by operating activities and, subject to favorable market and other conditions, the successful completion of future borrowings and potential refinancing. However, our cash requirements could be materially affected by the use of cash in acquisitions of businesses, repurchases of securities, the exercise of put rights or other exit options by our joint venture partners, and contractual commitments to fund capital expenditures in, or intercompany borrowings to, businesses we own. In addition, liquidity could be adversely affected by a deterioration in our results of operations, including our ability to generate cash from operations, as well as by the various risks and uncertainties discussed in this and other sections of this report, including any costs associated with legal proceedings and government investigations described in Note 14 to our Consolidated Financial Statements.

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

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are capital allocation priorities, volume growth, including the acquisition of outpatient businesses, physician recruitment and alignment strategies, expansion of our Conifer services businesses, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, non-core hospitals and portfolio optimization, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management company peers because of geographic and other differences in hospital portfolios.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the years ended December 31, 2016, 2015 and 2014 include $2 million, $94 million and $49 million, respectively, of net operating revenues and ($7) million, $15 million and ($1) million, respectively, of operating income (loss) generated from hospitals operated by us under operating lease arrangements (one hospital in the year ended December 31, 2016, which was sold effective March 31, 2016 and two hospitals in the years ended December 31, 2015 and 2014). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $128 million of standby letters of credit outstanding and guarantees at December 31, 2016.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 21 to our Consolidated Financial Statements included in this report for a discussion of recently issued accounting standards.

CRITICAL ACCOUNTING ESTIMATES

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

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

Our critical accounting estimates cover the following areas:

- Recognition of net operating revenues, including contractual allowances and provision for doubtful accounts;
- Accruals for general and professional liability risks;
- Accruals for defined benefit plans;
- Impairment of long-lived assets;
- Impairment of goodwill; and
- Accounting for income taxes.

REVENUE RECOGNITION

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, and managed care and other health plans, as well as certain uninsured patients under the Compact.

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more

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

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of December 31, 2016, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

Revenues related to self-pay patients may qualify for a discount under the Compact, whereby the gross charges based on established billing rates would be reduced by an estimated discount for contractual allowance.

We believe that adequate provision has been made for any adjustments that may result from final determination of amounts earned under all the above arrangements. We know of no material claims, disputes or unsettled matters with any payers that would affect our revenues for which we have not adequately provided for in our Consolidated Financial Statements.

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state statutes and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because

the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2016, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonable likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Our practice is to reduce the net carrying value of self-pay accounts receivable, including accounts related to the co-pays and deductibles due from patients with insurance, to their estimated net realizable value at the time of billing. Generally, uncollected balances are assigned to Conifer between 90 to 180 days, once patient responsibility has been identified. When accounts are assigned to Conifer by the hospital, the accounts are completely written off the hospital's books through the provision for doubtful accounts, and an estimated future recovery amount is calculated and recorded as a receivable on the hospital's books at the same time. The estimated future recovery amount is adjusted based on the aging of the accounts and changes to actual recovery rates. The estimated future recovery amount for self-pay accounts is written down whereby it is fully reserved if the amount is not paid within two years after the account is assigned to Conifer. At the present time, our more recent acquisitions have not yet been fully integrated into our Conifer collections processes.

Managed care accounts are collected through the regional business offices of Conifer, whereby the account balances remain in the related hospital's patient accounting system and on the hospital's books, and are adjusted based on an analysis of the net realizable value as they age. Generally, managed care accounts collected by Conifer are gradually written down whereby they are fully reserved if the accounts are not paid within two years.

Changes in the collectability of aged managed care accounts receivable are ongoing and impact our provision for doubtful accounts. We continue to experience payment pressure from managed care companies concerning amounts of past billings. We aggressively pursue collection of these accounts receivable using all means at our disposal, including arbitration and litigation, but we may not be successful.

ACCRUALS FOR GENERAL AND PROFESSIONAL LIABILITY RISKS

We accrue for estimated professional and general liability claims, to the extent not covered by insurance, when they are probable and can be reasonably estimated. We maintain reserves, which are based on modeled estimates for the portion of our professional liability risks, including incurred but not reported claims, to the extent we do not have insurance coverage. Our liability consists of estimates established based upon discounted calculations using several factors, including the number of expected claims, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, the timing of historical payments, and risk free discount rates used to determine the present value of projected payments. We consider the number of expected claims, average cost per claim and discount rate to be the most significant assumptions in estimating accruals for general and professional liabilities. Our liabilities are adjusted for new claims information in the period such information becomes known. Malpractice expense is recorded within other operating expenses in the accompanying Consolidated Statements of Operations.

Our estimated reserves for professional and general liability claims will change significantly if future trends differ from projected trends. We believe it is reasonably likely for there to be a 500 basis point increase or decrease in our

frequency or severity trend. Based on our reserves and other information at December 31, 2016, a 500 basis point increase in our frequency trend would increase the estimated reserves by $71 million, and a 500 decrease in our frequency trend would decrease the estimated reserves by $53 million. A 500 basis point increase in our severity trend would increase the estimated reserves by $93 million, and a 500 basis point decrease in our severity trend would decrease the estimated reserves by $77 million. Because our estimated reserves for future claim payments are discounted to present value, a change in our discount rate assumption could also have a significant impact on our estimated reserves. Our discount rate was 2.25%, 2.09% and 1.97% at December 31, 2016, 2015 and 2014, respectively. A 100 basis point increase or decrease in the discount rate would change the estimated reserves by $22 million. In addition, because of the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes, our ultimate liability for professional and general liability claims could change materially from our current estimates.

The table below shows the case reserves and incurred but not reported and loss development reserves as of December 31, 2016, 2015 and 2014:

	December 31,		
	2016	2015	2014
Case reserves	$ 189	$ 219	$ 253
Incurred but not reported and loss development reserves	675	584	472
Total undiscounted reserves	$ 864	$ 803	$ 725

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

Malpractice claims generally take four to five years to settle from the time of the initial reporting of the occurrence to the settlement payment. Accordingly, the percentage of undiscounted reserves at both December 31, 2016 and 2015 representing unsettled claims is approximately 98%.

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

	Years Ended December 31,		
	2016	2015	2014
Accrual for professional and general liability claims, beginning of the year	$ 755	$ 681	$ 711
Assumed from acquisition	—	29	—
Expense (income) related to:[1]			
Current year	228	151	144
Prior years	43	95	57
Expense (income) from discounting	(4)	(3)	7
Total incurred loss and loss expense	267	243	208
Paid claims and expenses related to:			
Current year	—	(3)	(3)
Prior years	(228)	(195)	(235)
Total paid claims and expenses	(228)	(198)	(238)
Accrual for professional and general liability claims, end of year	$ 794	$ 755	$ 681

(1) Total malpractice expense for continuing operations, including premiums for insured coverage, was $281 million, $283 million and $232 million in the years ended December 31, 2016, 2015 and 2014, respectively.

ACCRUALS FOR DEFINED BENEFIT PLANS

Our defined benefit plan obligations and related costs are calculated using actuarial concepts. The discount rate is a critical assumption in determining the elements of expense and liability measurement. We evaluate this critical assumption annually. Other assumptions include employee demographic factors such as retirement patterns, mortality, turnover and rate of compensation increase. During the years ended December 31, 2016 and 2015, the Society of Actuaries issued new mortality improvement scales (MP-2016 and MP-2015, respectively), which we incorporated into the estimates of our defined benefit plan obligations at December 31, 2016 and 2015.

The discount rate enables us to state expected future cash payments for benefits as a present value on the measurement date. The guideline for setting these rates is a high-quality long-term corporate bond rate. A lower discount rate increases the present value of benefit obligations and impacts pension expense. Our discount rates for 2016 ranged from 4.25% to 4.42% and our discount rate for 2015 ranged from 4.67% to 4.75%. The assumed discount rate for pension plans reflects the market rates for high-quality corporate bonds currently available. A 100 basis point decrease in the assumed discount rate would increase total net periodic pension expense for 2017 by approximately $3 million and would increase the projected benefit obligation at December 31, 2016 by approximately $187 million. A 100 basis point increase in the assumed discount rate would decrease net periodic pension expense for 2017 by approximately $3 million and decrease the projected benefit obligation at December 31, 2016 by approximately $154 million.

IMPAIRMENT OF LONG-LIVED ASSETS

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

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

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

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

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

- how the hospitals are operated in the future; and

- the nature of the ultimate disposition of the assets.

During the year ended December 31, 2016, we recorded $87 million of impairment charges. This amount included charges of approximately $54 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at four of our hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, these hospitals are at risk of future impairments, particularly if we spend significant amounts of capital at the hospitals without generating a corresponding increase in the hospitals' fair value or if the fair value of the hospitals' real estate or equipment declines. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $163 million as of December 31, 2016 after recording the impairment charges. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract related intangibles and capitalized software costs not associated with the hospitals described above. Of the total impairment charges recognized for the year ended December 31, 2016, $76 million related to our Hospital Operations and other segment, $8 million related to our Ambulatory Care segment, and $3 million related to our Conifer segment. We also had three hospitals whose estimated future undiscounted cash flows did not exceed the carrying value of long-lived assets. However, in each case, the fair value of those assets, based on independent appraisals, established market values of comparable assets or internal estimates exceeded the carrying value, so no impairment was recorded. Future adverse trends that result in necessary changes in the assumptions underlying these estimates of future undiscounted cash flows could result in the hospitals' estimated cash flows being less than the carrying value of the assets, which would require a fair value assessment of the long-lived assets and, if the fair value amount is less than the carrying value of the assets, impairment charges would occur and could be material.

During the year ended December 31, 2015, we recorded $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 4. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million related to investments. We also had four hospitals whose estimated future undiscounted cash flows did not exceed the carrying value of long-lived assets. However, in each case, the fair value of those assets, based on independent appraisals, established market values of comparable assets or internal estimates exceeded the carrying value, so no impairment was recorded. Future adverse trends that result in necessary changes in the assumptions underlying these estimates of future undiscounted cash flows could result in the hospitals' estimated cash flows being less than the carrying value of the assets, which would require a fair value assessment of the long-lived assets and, if the fair value amount is less than the carrying value of the assets, impairment charges would occur and could be material.

IMPAIRMENT OF GOODWILL

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

declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

As of December 31, 2016, our continuing operations consisted of three reportable segments, Hospital Operations and other, Ambulatory Care and Conifer. Within our Hospital Operations and other segment, our regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our reportable business segment level.

Our Hospital Operations and other segment was structured as follows at December 31, 2016:

- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region included all of our hospitals and other operations in Alabama, Missouri, South Carolina and Tennessee;
- Our Texas region included all of our hospitals and other operations in New Mexico and Texas;
- Our Western region included all of our hospitals and other operations in Arizona and California; and
- Our Detroit market included all of our hospitals and other operations in the Detroit, Michigan area.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level. We also perform a goodwill impairment analysis for our Conifer and Ambulatory Care reporting units.

The allocated goodwill balance related to our Hospital Operations and other segment totals approximately $3.373 billion, of which the Texas Region has the largest balance at $1.894 billion. In our latest impairment analysis as of December 31, 2016, the estimated fair value of the Texas Region exceeded the carrying value of long-lived assets, including goodwill, by approximately 11%.

The allocated goodwill balance related to our Ambulatory Care segment, consisting generally of assets acquired in 2015 and 2016, totals approximately $3.447 billion. For the Ambulatory Care segment, we performed a qualitative analysis under the Financial Accounting Standards Board's Accounting Standards Update 2011-08, "Intangibles—Goodwill and Other (Topic 350): Testing Goodwill for Impairment," and concluded that it was more likely than not that the fair value of the reporting unit exceeded its carrying value. Factors considered in the analysis included the length of time since the acquisition date fair value analyses were performed, recent and estimated future operating trends.

The allocated goodwill balance related to our Conifer segment totals approximately $605 million. In our latest impairment analysis as of December 31, 2016, the estimated fair value of the Conifer segment exceeded the carrying value of long-lived assets, including goodwill, by approximately 135%.

ACCOUNTING FOR INCOME TAXES

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

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

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

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

During the year ended December 31, 2015, we increased the valuation allowance by $9 million, $5 million due to the acquisition of USPI and $4 million due to changes in expected realizability of deferred tax assets, primarily related to unutilized state net operating loss carryforwards. During the year ended December 31, 2016, we decreased the valuation allowance by $24 million primarily due to the expiration or worthlessness of unutilized state net operating loss carryovers. The remaining balance in the valuation allowance as of December 31, 2016 is $72 million.

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

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

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments at December 31, 2016. The fair values were determined based on quoted market prices for the same or similar instruments. The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2017	2018	2019	2020	2021	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 191	$ 1,157	$ 1,694	$ 3,421	$ 1,958	$ 6,169	$ 14,590	$ 13,653
Average effective interest rates	6.2 %	6.5 %	5.5 %	6.7 %	4.7 %	8.0 %	6.8 %	
Variable rate long-term debt	$ —	$ —	$ —	$ 900	$ —	$ —	$ 900	$ 896
Average effective interest rates	— %	— %	— %	4.5 %	— %	— %	4.5 %	

At December 31, 2016, the potential reduction of annual pre-tax earnings due to a one percentage point (100 basis point) increase in variable interest rates on long-term debt would be approximately $9 million.

At December 31, 2016, we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

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

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

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

MANAGEMENT REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

To Our Shareholders:

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended. Management assessed the effectiveness of Tenet's internal control over financial reporting as of December 31, 2016. This assessment was performed under the supervision of and with the participation of management, including the chief executive officer and chief financial officer.

In making this assessment, management used criteria based on the framework in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on the assessment using the COSO framework, management concluded that Tenet's internal control over financial reporting was effective as of December 31, 2016.

Tenet's internal control over financial reporting as of December 31, 2016 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report, which is included herein. Deloitte & Touche LLP has also audited Tenet's Consolidated Financial Statements as of and for the year ended December 31, 2016, and that firm's audit report on such Consolidated Financial Statements is also included herein.

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

/s/ TREVOR FETTER
Trevor Fetter
Chief Executive Officer and Chairman of the Board of Directors
February 27, 2017

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer
February 27, 2017

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2016, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2016, of the Company and our report dated February 27, 2017, expressed an unqualified opinion on those consolidated financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 27, 2017

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income (loss), changes in equity, and cash flows for each of the three years in the period ended December 31, 2016. Our audits also included the consolidated financial statement schedule listed in the Index at Item 15. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the consolidated financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Company at December 31, 2016 and 2015, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2016, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2016, based on the criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 27, 2017, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 27, 2017

CONSOLIDATED BALANCE SHEETS
Dollars in Millions

	December 31, 2016	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 716	$ 356
Accounts receivable, less allowance for doubtful accounts ($1,031 at December 31, 2016 and $887 at December 31, 2015)	2,897	2,704
Inventories of supplies, at cost	326	309
Income tax receivable	4	7
Assets held for sale	29	550
Other current assets	1,285	1,245
Total current assets	5,257	5,171
Investments and other assets	1,250	1,175
Deferred income taxes	871	776
Property and equipment, at cost, less accumulated depreciation and amortization ($4,974 at December 31, 2016 and $4,323 at December 31, 2015)	8,053	7,915
Goodwill	7,425	6,970
Other intangible assets, at cost, less accumulated amortization ($772 at December 31, 2016 and $659 at December 31, 2015)	1,845	1,675
Total assets	$ 24,701	$ 23,682
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 191	$ 127
Accounts payable	1,329	1,380
Accrued compensation and benefits	872	880
Professional and general liability reserves	181	177
Accrued interest payable	210	205
Liabilities held for sale	9	101
Accrued legal settlement costs	8	294
Other current liabilities	1,234	1,144
Total current liabilities	4,034	4,308
Long-term debt, net of current portion	15,064	14,383
Professional and general liability reserves	613	578
Defined benefit plan obligations	626	595
Deferred income taxes	279	37
Other long-term liabilities	610	557
Total liabilities	21,226	20,458
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	2,393	2,266
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 148,106,249 shares issued at December 31, 2016 and 146,920,454 shares issued at December 31, 2015	7	7
Additional paid-in capital	4,827	4,815
Accumulated other comprehensive loss	(258)	(164)
Accumulated deficit	(1,742)	(1,550)
Common stock in treasury, at cost, 48,420,650 shares at December 31, 2016 and 48,425,298 shares at December 31, 2015	(2,417)	(2,417)
Total shareholders' equity	417	691
Noncontrolling interests	665	267
Total equity	1,082	958
Total liabilities and equity	$ 24,701	$ 23,682

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2016	2015	2014
Net operating revenues:			
Net operating revenues before provision for doubtful accounts	$ 21,070	$ 20,111	$ 17,908
Less: Provision for doubtful accounts	1,449	1,477	1,305
Net operating revenues	**19,621**	**18,634**	**16,603**
Equity in earnings of unconsolidated affiliates	**131**	**99**	**12**
Operating expenses:			
Salaries, wages and benefits	9,356	9,011	8,023
Supplies	3,124	2,963	2,630
Other operating expenses, net	4,891	4,555	4,114
Electronic health record incentives	(32)	(72)	(104)
Depreciation and amortization	850	797	849
Impairment and restructuring charges, and acquisition-related costs	202	318	153
Litigation and investigation costs	293	291	25
Gains on sales, consolidation and deconsolidation of facilities	(151)	(186)	—
Operating income	**1,219**	**1,056**	**925**
Interest expense	(979)	(912)	(754)
Loss from early extinguishment of debt	—	(1)	(24)
Investment earnings	8	1	—
Net income from continuing operations, before income taxes	**248**	**144**	**147**
Income tax expense	(67)	(68)	(49)
Net income from continuing operations, before discontinued operations	**181**	**76**	**98**
Discontinued operations:			
Net loss from operations	(6)	(5)	(17)
Litigation and investigation (costs) benefit	—	8	(18)
Income tax benefit (expense)	1	(1)	13
Net income (loss) from discontinued operations	**(5)**	**2**	**(22)**
Net income	**176**	**78**	**76**
Less: Net income attributable to noncontrolling interests	368	218	64
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ (192)**	**$ (140)**	**$ 12**
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders			
Net income (loss) from continuing operations, net of tax	$ (187)	$ (142)	$ 34
Net income (loss) from discontinued operations, net of tax	(5)	2	(22)
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ (192)**	**$ (140)**	**$ 12**
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ (1.88)	$ (1.43)	$ 0.35
Discontinued operations	(0.05)	0.02	(0.23)
	$ (1.93)	**$ (1.41)**	**$ 0.12**
Diluted			
Continuing operations	$ (1.88)	$ (1.43)	$ 0.34
Discontinued operations	(0.05)	0.02	(0.22)
	$ (1.93)	**$ (1.41)**	**$ 0.12**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	99,321	99,167	97,801
Diluted	99,321	99,167	100,287

See accompanying Notes to Consolidated Financial Statements.

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

	Years Ended December 31,		
	2016	2015	2014
Net income	$ 176	$ 78	$ 76
Other comprehensive income (loss):			
Adjustments for defined benefit plans	(73)	3	(258)
Amortization of net actuarial loss included in net periodic benefit costs	12	12	4
Unrealized gains (losses) on securities held as available-for-sale	2	(2)	3
Foreign currency translation adjustments	(53)	5	—
Other comprehensive income (loss) before income taxes	**(112)**	**18**	**(251)**
Income tax benefit (expense) related to items of other comprehensive income (loss)	18	—	93
Total other comprehensive income (loss), net of tax	**(94)**	**18**	**(158)**
Comprehensive net income (loss)	**82**	**96**	**(82)**
Less: Comprehensive income attributable to noncontrolling interests	**368**	**218**	**64**
Comprehensive loss attributable to Tenet Healthcare Corporation common shareholders	**$ (286)**	**$ (122)**	**$ (146)**

See accompanying Notes to Consolidated Financial Statements.

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

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balance at December 31, 2013	96,860	$ 7	$ 4,572	$ (24)	$ (1,422)	$ (2,378)	$ 123	$ 878
Net income	—	—	—	—	12	—	31	43
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(37)	(37)
Contributions from noncontrolling interests	—	—	—	—	—	—	7	7
Other comprehensive income	—	—	—	(158)	—	—	—	(158)
Purchases (sales) of businesses and noncontrolling interests	—	—	(22)	—	—	—	10	(12)
Stock-based compensation expense and issuance of common stock	1,522	—	64	—	—	—	—	64
Balances at December 31, 2014	98,382	$ 7	$ 4,614	$ (182)	$ (1,410)	$ (2,378)	$ 134	$ 785
Net income (loss)	—	—	—	—	(140)	—	52	(88)
Distributions paid to nncontrolling interests	—	—	—	—	—	—	(50)	(50)
Contributions from noncontrolling interests	—	—	—	—	—	—	3	3
Other comprehensive income	—	—	—	18	—	—	—	18
Purchases (sales) of businesses and noncontrolling interests	—	—	124	—	—	—	128	252
Repurchases of common stock	(1,243)	—	—	—	—	(40)	—	(40)
Stock-based compensation expense and issuance of common stock	1,356	—	77	—	—	1	—	78
Balances at December 31, 2015	98,495	$ 7	$ 4,815	$ (164)	$ (1,550)	$ (2,417)	$ 267	$ 958
Net income (loss)	—	—	—	—	(192)	—	138	(54)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(111)	(111)
Other comprehensive loss	—	—	—	(94)	—	—	—	(94)
Purchases (sales) of businesses and noncontrolling interests	—	—	(40)	—	—	—	146	106
Purchase accounting adjustments	—	—	—	—	—	—	225	225
Stock-based compensation expense, tax benefit and issuance of common stock	1,191	—	52	—	—	—	—	52
Balances at December 31, 2016	99,686	$ 7	$ 4,827	$ (258)	$ (1,742)	$ (2,417)	$ 665	$ 1,082

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2016	2015	2014
Net income	$ 176	$ 78	$ 76
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	850	797	849
Provision for doubtful accounts	1,449	1,477	1,305
Deferred income tax expense	41	42	30
Stock-based compensation expense	68	69	51
Impairment and restructuring charges, and acquisition-related costs	202	318	153
Litigation and investigation costs	293	291	25
Loss from early extinguishment of debt	—	1	24
Gains on sales, consolidation and deconsolidation of facilities	(151)	(186)	—
Equity in earnings of unconsolidated affiliates, net of distributions received	(13)	(99)	(10)
Amortization of debt discount and debt issuance costs	41	41	28
Pre-tax (income) loss from discontinued operations	6	(3)	35
Other items, net	(1)	59	(30)
Changes in cash from operating assets and liabilities:			
Accounts receivable	(1,604)	(1,632)	(1,896)
Inventories and other current assets	(83)	(130)	(314)
Income taxes	(8)	18	3
Accounts payable, accrued expenses and other current liabilities	(51)	68	505
Other long-term liabilities	40	38	44
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	(691)	(200)	(168)
Net cash used in operating activities from discontinued operations, excluding income taxes	(6)	(21)	(23)
Net cash provided by operating activities	558	1,026	687
Cash flows from investing activities:			
Purchases of property and equipment — continuing operations	(875)	(842)	(933)
Purchases of businesses or joint venture interests, net of cash acquired	(117)	(940)	(428)
Proceeds from sales of facilities and other assets	573	549	6
Proceeds from sales of marketable securities, long-term investments and other assets	62	60	52
Purchases of equity investments	(39)	(134)	(12)
Other assets	(31)	(4)	(8)
Other items, net	(3)	(6)	1
Net cash used in investing activities	(430)	(1,317)	(1,322)
Cash flows from financing activities:			
Repayments of borrowings under credit facility	(1,895)	(2,815)	(2,430)
Proceeds from borrowings under credit facility	1,895	2,595	2,245
Repayments of other borrowings	(154)	(2,049)	(683)
Proceeds from other borrowings	760	3,158	1,608
Repurchases of common stock	—	(40)	—
Debt issuance costs	(12)	(80)	(27)
Distributions paid to noncontrolling interests	(218)	(110)	(45)
Proceeds from sale of noncontrolling interests	22	11	
Purchase of noncontrolling interests	(186)	(268)	—
Proceeds from exercise of stock options	4	15	26
Other items, net	16	37	21
Net cash provided by financing activities	232	454	715
Net increase in cash and cash equivalents	360	163	80
Cash and cash equivalents at beginning of period	356	193	113
Cash and cash equivalents at end of period	$ 716	$ 356	$ 193
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (932)	$ (859)	$ (726)
Income tax payments, net	$ (33)	$ (7)	$ (8)

See accompanying Notes to Consolidated Financial Statements.

Attachment
15

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. At December 31, 2016, we operated 79 hospitals, 20 short-stay surgical hospitals, approximately 470 outpatient centers, nine facilities in the United Kingdom and six health plans (certain of which are classified as held for sale, as described in Note 4) through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI joint venture"). We hold noncontrolling interests in 124 facilities, which are recorded using the equity method of accounting. Our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into our new USPI joint venture. We also refinanced approximately $1.5 billion of existing USPI debt and paid approximately $424 million to align the respective valuations of the assets contributed to the joint venture. In April 2016, we paid approximately $127 million to purchase additional shares, which increased our ownership interest in the USPI joint venture from 50.1% to approximately 56.3%. In addition, we completed the acquisition of European Surgical Partners Ltd. ("Aspen") for approximately $226 million on June 16, 2015. Aspen has nine private hospitals and clinics in the United Kingdom.

Basis of Presentation

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

Certain prior-year amounts have also been reclassified to conform to current-year presentation, primarily related to the lines presented on our Consolidated Statements of Cash Flows.

Use of Estimates

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

Translation of Foreign Currencies

The accounts of Aspen were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities were translated using the current rate of exchange at the balance sheet date. Results of operations were translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates are accumulated in shareholders' equity. Deferred U.S. taxes have not been provided with respect to translation gains or losses because Aspen's accumulated earnings are indefinitely reinvested outside the United States.

Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("Compact") and other uninsured discount and charity programs.

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

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

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted. Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2016, 2015 and 2014 by $54 million, $64 million, and $20 million, respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Consolidated Balance Sheets (see Note 3). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to

adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for these payers and other factors that affect the estimation process.

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

Under our Compact or other uninsured discount programs, the discount offered to certain uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

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

The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Years Ended December 31,		
	2016	2015	2014
General Hospitals:			
Medicare	$ 3,374	$ 3,403	$ 3,395
Medicaid	1,346	1,451	1,482
Managed care	10,126	10,098	9,027
Indemnity, self-pay and other	1,621	1,726	1,561
Acute care hospitals — other revenue	21	63	53
Other:			
Other operations	4,582	3,370	2,390
Net operating revenues before provision for doubtful accounts	**$ 21,070**	**$ 20,111**	**$ 17,908**

Provision for Doubtful Accounts

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state statutes and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that

can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Electronic Health Record Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"), federal incentive payments are available to hospitals, physicians and certain other professionals when they adopt, implement or upgrade ("AIU") certified electronic health record ("EHR") technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved. During the years ended December 31, 2016, 2015 and 2014, certain of our hospitals and physicians satisfied the CMS AIU and/or meaningful use criteria. As a result, we recognized approximately $32 million, $72 million and $104 million of Medicare and Medicaid EHR incentive payments as a reduction to expense in our Consolidated Statement of Operations for the years ended December 31, 2016, 2015 and 2014, respectively.

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $716 million and $356 million at December 31, 2016 and 2015, respectively. As of December 31, 2016 and 2015, our book overdrafts were approximately $279 million and $301 million, respectively, which were classified as accounts payable.

At December 31, 2016 and 2015, approximately $232 million and $171 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries and our health plan-related businesses.

Also at December 31, 2016 and 2015, we had $179 million and $133 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $141 million and $95 million, respectively, were included in accounts payable.

During the years ended December 31, 2016 and 2015, we entered into non-cancellable capital leases of approximately $160 million and $162 million, respectively, primarily for equipment.

Investments in Debt and Equity Securities

We classify investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2016 and 2015, we had no significant investments in securities classified as either held-to-maturity or trading. We carry securities classified as available-for-sale at fair value. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determine that a loss is other-than-temporary, at which point we would record a loss in our consolidated statements of operations. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Investments in Unconsolidated Affiliates

We control 215 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 (108 of 323 at December 31, 2016), four of the hospitals our Hospital Operations and other segment operates, and 12 additional facilities in which our Hospital Operations and other segment holds a ownership interests under the equity method as investments in unconsolidated affiliates and report only our share of net income attributable to the investee as equity in earnings of unconsolidated affiliates in the accompanying Consolidated Statements of Operations. Summarized financial information for these equity method investees is included in the following table. For investments acquired during the reported periods, amounts reflect 100% of the investee's results beginning on the date of our acquisition of the investment.

	December 31, 2016	December 31, 2015
Current assets	$ 943	$ 866
Noncurrent assets	$ 991	$ 854
Current liabilities	$ (320)	$ (301)
Noncurrent liabilities	$ (345)	$ (377)
Noncontrolling interests	$ (494)	$ (309)

	Years Ended December 31,	
	2016	2015
Net operating revenues	$ 2,823	$ 1,335
Net income	$ 573	$ 436
Net income attributable to the investees	$ 343	$ 356

Our equity method investment that contributes the most to our equity in earnings of unconsolidated affiliates is Texas Health Ventures Group, LLC ("THVG"), which is operated by our USPI joint venture. THVG represented $61 million of the total $131 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2016 and $35 million of the total $99 million equity in earnings of unconsolidated affiliates we recognized for the year ended December 31, 2015.

Property and Equipment

Additions and improvements to property and equipment exceeding established minimum amounts with a useful life greater than one year are capitalized at cost. Expenditures for maintenance and repairs are charged to expense as incurred. We use the straight-line method of depreciation for buildings, building improvements and equipment. The estimated useful life for buildings and improvements is primarily 15 to 40 years, and for equipment three to 15 years. Newly constructed hospitals are usually depreciated over 50 years. We record capital leases at the beginning of the lease term as assets and liabilities. The value recorded is the lower of either the present value of the minimum lease payments or the fair value of the asset. Such assets, including improvements, are generally amortized over the shorter of either the lease term or their estimated useful life. Interest costs related to construction projects are capitalized. In the years ended December 31, 2016, 2015 and 2014, capitalized interest was $22 million, $12 million and $25 million, respectively.

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment if the carrying value of the long-lived assets exceeds the

fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

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

Goodwill and Other Intangible Assets

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

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

Accruals for General and Professional Liability Risks

We accrue for estimated professional and general liability claims, when they are probable and can be reasonably estimated. The accrual, which includes an estimate for incurred but not reported claims, is updated each quarter based on a model of projected payments using case-specific facts and circumstances and our historical loss reporting, development and settlement patterns and is discounted to its net present value using a risk-free discount rate 2.25% at December 31, 2016 and 2.09% at December 31, 2015. To the extent that subsequent claims information varies from our estimates, the liability is adjusted in the period such information becomes available. Malpractice expense is presented within other operating expenses in the accompanying Consolidated Statements of Operations.

Income Taxes

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

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

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such

evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

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

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

Segment Reporting

We primarily operate acute care hospitals and related healthcare facilities. Our general hospitals generated 78%, 83% and 87% of our net operating revenues before provision for doubtful accounts in the years ended December 31, 2016, 2015 and 2014, respectively. Each of our operating regions and markets related to our general hospitals report directly to our president of hospital operations. Major decisions, including capital resource allocations, are made at the consolidated level, not at the regional, market or hospital level.

Our Hospital Operations and other segment is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals, physician practices and health plans (certain of which are classified as held for sale as described in Note 4). In the three months ended June 30, 2015, we began reporting Ambulatory Care as a separate reportable business segment. Previously, our business consisted of our Hospital Operations and other segment and our Conifer segment, which provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

Effective June 16, 2015, we completed the joint venture transaction that combined our freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets. We contributed our interests in 49 ambulatory surgery centers and 20 imaging centers, which had previously been included in our Hospital Operations and other segment, to the joint venture. We also completed the acquisition of Aspen effective June 16, 2015, which includes nine private hospitals and clinics in the United Kingdom. Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and Aspen facilities. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Costs Associated With Exit or Disposal Activities

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

NOTE 2. EQUITY

Noncontrolling Interests

Our noncontrolling interests balances at December 31, 2016 and 2015 in our Consolidated Statements of Shareholders' Equity were comprised of $89 million and $20 million, respectively, from our Hospital Operations and other segment, and $576 million and $247 million, respectively, from our Ambulatory Care segment. Our net income attributable to noncontrolling interests for the years ended December 31, 2016, 2015 and 2014 were comprised of $11 million, $24 million and $30 million, respectively, from our Hospital Operations and other segment, and $127 million, $28 million and $1 million, respectively, from our Ambulatory Care segment.

Share Repurchase Program

In November 2015, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2016. Pursuant to the share repurchase program, we paid approximately $40 million to repurchase a total of 1,242,806 shares during the period from the commencement of the program through December 31, 2015. There were no purchases under the program during the year ended December 31, 2016.

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
November 1, 2015 through November 30, 2015	978	$ 32.71	978	$ 468
December 1, 2015 through December 31, 2015	265	30.25	265	460
November 1, 2015 through December 31, 2015	**1,243**	**$ 32.18**	**1,243**	**$ 460**

NOTE 3. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

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

	December 31, 2016	December 31, 2015
Continuing operations:		
Patient accounts receivable	$ 3,799	$ 3,486
Allowance for doubtful accounts	(1,031)	(887)
Estimated future recoveries	141	144
Net cost reports and settlements payable and valuation allowances	(14)	(42)
	2,895	2,701
Discontinued operations	2	3
Accounts receivable, net	**$ 2,897**	**$ 2,704**

At December 31, 2016 and 2015, our allowance for doubtful accounts was 27.1% and 25.4%, respectively, of our patient accounts receivable. Our allowance was impacted by higher patient co–pays and deductibles, as well increases in our uninsured revenues and volumes during the three months ended December 31, 2016 compared to the same period in 2015. Additionally, the composition of our accounts receivable has been impacted by our acquisition and divestiture activity.

Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this

allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. At December 31, 2016 and 2015, our allowance for doubtful accounts for self-pay was 85.4% and 80.6%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. At December 31, 2016 and 2015, our allowance for doubtful accounts for managed care was 9.9% and 7.5%, respectively, of our managed care patient accounts receivable.

Accounts assigned to our Conifer subsidiary are written off and excluded from patient accounts receivable and allowance for doubtful accounts; however, an estimate of future recoveries from all accounts at our Conifer subsidiary is determined based on historical experience and recorded on our hospitals' books as a component of accounts receivable in the accompanying Consolidated Balance Sheets. At the present time, our more recent acquisitions have not yet been fully integrated into our Conifer collections processes.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The table below shows our estimated costs of caring for our self-pay patients and charity care patients and revenues attributable to Medicaid DSH and other supplement revenues we recognize for the years ended December 31, 2016, 2015 and 2014.

	Years Ended December 31,		
	2016	2015	2014
Estimated costs for:			
Self-pay patients	$ 644	$ 678	$ 620
Charity care patients	$ 146	$ 191	$ 180
Medicaid DSH and other supplemental revenues	$ 906	$ 888	$ 817

At December 31, 2016 and 2015, we had approximately $537 million and $387 million, respectively, of receivables recorded in other current assets and approximately $139 million and $139 million, respectively, of payables recorded in other current liabilities in the accompanying Consolidated Balance Sheets related to California's provider fee program.

NOTE 4. ASSETS AND LIABILITIES HELD FOR SALE

In the three months ended September 30, 2016, certain of our health plan assets and liabilities met the criteria to be classified as held for sale. In accordance with the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," we classified $27 million of our health plan assets as "assets held for sale" in current assets and $13 million of our health plan liabilities as "liabilities held for sale" in current liabilities in the accompanying Consolidated Balance Sheet at December 31, 2016.

Our hospitals, physician practices and related assets in Georgia met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. In accordance with ASC 360, we classified $549 million of our assets in Georgia as "assets held for sale" in current assets and $101 million of our liabilities in Georgia as "liabilities held for sale" in current liabilities in the accompanying Consolidated Balance Sheet at December 31, 2015. We completed the sale of our Georgia assets on March 31, 2016 at a transaction price of approximately $575 million and recognized a gain on sale of approximately $113 million. Because we did not sell the related accounts receivable with respect to the pre-closing period, net receivables of approximately $46 million are included in accounts receivable, less allowance for doubtful accounts in the accompanying Consolidated Balance Sheet at December 31, 2016.

In the three months ended June 30, 2015, we entered into a definitive agreement for the sale of the assets of our Saint Louis University Hospital ("SLUH") to Saint Louis University. In accordance with the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," we classified SLUH's assets as "assets held for sale" in current assets and SLUH's liabilities as "liabilities held for sale" in current liabilities in our Consolidated Balance Sheet at June 30, 2015. These assets and liabilities were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. As a result of this anticipated transaction, we recorded an impairment charge of $147 million for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell, in the three months ended June 30, 2015. We completed the sale of SLUH on August 31, 2015 at a transaction price of approximately $32 million, excluding working capital and subject to customary purchase price adjustments. Because we did not sell SLUH's accounts receivable related to the pre-closing period, net receivables of approximately $12 million are included in accounts receivable, less allowance for doubtful accounts, in the accompanying Consolidated Balance Sheet at December 31, 2016.

Our hospitals, physician practices and related assets in North Carolina also met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. We completed the sale of our North Carolina assets on December 31, 2015 at a transaction price of approximately $191 million and recognized a gain on sale of approximately $3 million. Because we did not sell the related accounts receivable related to the pre-closing period, net receivables of approximately $8 million are included in accounts receivable, less allowance for doubtful accounts in the accompanying Consolidated Balance Sheet at December 31, 2016.

During the three months ended March 31, 2015, we entered into definitive agreements to form two joint ventures with affiliates of Baylor Scott & White Holdings ("BSW Holdings"), the parent company of Baylor Scott & White Health, involving the ownership and operation of the hospitals formerly known as Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center and Texas Regional Medical Center at Sunnyvale (collectively, "our North Texas hospitals") – which we continue to operate – and Baylor Medical Center at Garland – which is operated by an affiliate of BSW Holdings, which, through its affiliates, holds a majority ownership interest in the joint ventures. The transactions closed on December 31, 2015 at a net transaction price of approximately $288 million, and we recorded a gain on deconsolidation of these facilities of approximately $151 million. We also recorded an equity investment in the new joint ventures of approximately $164 million, which included $11 million of cash contributed at closing.

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

We recognized impairment charges on long-lived assets in 2016, 2015 and 2014 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in healthcare industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

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

At December 31, 2016, our continuing operations consisted of three reportable segments, Hospital Operations and other, Ambulatory Care and Conifer. Within our Hospital Operations and other segment, our regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our reportable business segments.

Our Hospital Operations and other segment was structured as follows at December 31, 2016:

- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region included all of our hospitals and other operations in Alabama, Missouri, South Carolina and Tennessee;
- Our Texas region included all of our hospitals and other operations in New Mexico and Texas;
- Our Western region included all of our hospitals and other operations in Arizona and California; and
- Our Detroit market included all of our hospitals and other operations in the Detroit, Michigan area.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment. We also perform a goodwill impairment analysis for our Conifer and Ambulatory Care reporting units. Effective in January 2017, our Florida, Northeast and Southern regions and our Detroit market were combined to form our Eastern region. Our Eastern region includes all of our hospitals and other operations in Alabama, Florida, Illinois, Massachusetts, Michigan, Missouri, Pennsylvania, South Carolina and Tennessee. Subsequent to this change, our Hospital Operations and other segment is comprised of our Eastern, Texas and Western regions.

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

Year Ended December 31, 2016

During the year ended December 31, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $202 million. This amount included impairment charges of approximately $54 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at four of our hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, these hospitals are at risk of future impairments, particularly if we spend significant amounts of capital at the hospitals without generating a corresponding increase in the hospitals' fair value or if the fair value of the hospitals' real estate or equipment declines. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $163 million as of December 31, 2016 after recording the impairment charges. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract related intangibles and capitalized software costs not associated with the hospitals described above. Of the total impairment charges recognized for the year ended December 31, 2016, $76 million related to our Hospital Operations and other segment, $8 million related to our Ambulatory Care segment, and $3 million related to our Conifer segment. We also recorded $35 million of employee severance costs, $14 million of restructuring costs, $14 million of contract and lease termination fees, and $52 million in acquisition-related costs, which include $20 million of transaction costs and $32 million of acquisition integration costs.

Year Ended December 31, 2015

During the year ended December 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $318 million, including $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 4. We also recorded impairment charges of approximately $19 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million related to investments. We also recorded $25 million of employee severance costs, $6 million of restructuring costs, $19 million of contract and lease termination fees, and $100 million in acquisition-related costs, which include $55 million of transaction costs and $45 million of acquisition integration charges.

Year Ended December 31, 2014

During the year ended December 31, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $153 million. This amount included a $20 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $23 million as of December 31, 2014 after recording the impairment charge. We also recorded $16 million of employee severance costs, $19 million of contract and lease termination fees, $3 million of restructuring costs, and $95 million in acquisition-related costs, which include $16 million of transaction costs and $79 million of acquisition integration charges.

NOTE 6. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of December 31, 2016 and 2015:

	December 31, 2016	December 31, 2015
Senior unsecured notes:		
5% due 2019	$ 1,100	$ 1,100
5 1/2% due 2019	500	500
6 3/4% due 2020	300	300
8% due 2020	750	750
8 1/8% due 2022	2,800	2,800
6 3/4% due 2023	1,900	1,900
6 7/8% due 2031	430	430
Senior secured notes:		
6 1/4% due 2018	1,041	1,041
4 3/4% due 2020	500	500
6% due 2020	1,800	1,800
Floating % due 2020	900	900
4 1/2% due 2021	850	850
4 3/8% due 2021	1,050	1,050
7 1/2% due 2022	750	—
Capital leases and mortgage notes	819	852
Unamortized issue costs, note discounts and premiums	(235)	(263)
Total long-term debt	**15,255**	**14,510**
Less current portion	191	127
Long-term debt, net of current portion	**$ 15,064**	**$ 14,383**

Credit Agreement

We have a senior secured revolving credit facility (as amended, the "Credit Agreement") which provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of December 4, 2020, are guaranteed by substantially all of our domestic wholly-owned hospital subsidiaries and are secured by a first-priority lien on the accounts receivable owned by us and the subsidiary guarantors. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 0.25% to 0.75% per annum or the London Interbank Offered Rate ("LIBOR") plus a margin ranging from 1.25% to 1.75% per annum, in each case based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.25% to 0.375% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At December 31, 2016, we had no cash borrowings outstanding under the Credit Agreement and we had approximately $2 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $998 million was available for borrowing under the revolving Credit Agreement at December 31, 2016.

Letter of Credit Facility

We have a letter of credit facility (as amended, the "LC Facility") that provides for the issuance of standby and documentary letters of credit, from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). 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. On September 15, 2016, we entered into an amendment to the existing letter of credit facility agreement in order to, among other things, (i) extend the scheduled maturity date of the LC Facility to March 7, 2021, (ii) reduce the margin payable with respect to unreimbursed drawings under letters of credit and undrawn letters of credit issued under the LC Facility, and (iii) reduce the commitment fee payable with respect to the undrawn portion of the commitments under the LC Facility.

Drawings under any letter of credit issued under the LC Facility that we have not reimbursed within three business days after notice thereof accrue interest at a base rate plus a margin equal to 0.50% per annum. An unused commitment fee is payable at an initial rate of 0.25% per annum with a step up to 0.375% per annum should our secured debt to EBITDA ratio equal or exceed 3.00 to 1.00 at the end of any fiscal quarter. A fee on the aggregate outstanding amount of issued but undrawn letters of credit accrues at a rate of 1.50% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At December 31, 2016, we had approximately $108 million of standby letters of credit outstanding under the LC Facility.

Senior Secured Notes

All of our senior secured notes are guaranteed by certain of our wholly owned domestic hospital company subsidiaries and secured by a first-priority pledge of the capital stock and other ownership interests of those subsidiaries. Our 7½% senior secured second lien notes (the "Second Lien Notes"), are secured by a second-priority pledge of the capital stock and other ownership interests of those subsidiaries, and the remaining senior secured notes are secured by a first-priority pledge of the capital stock and other ownership interests of those subsidiaries. All of our senior secured notes and the related subsidiary guarantees are our and the subsidiary guarantors' senior secured obligations. All of our senior secured notes rank equally in right of payment with all of our other senior secured indebtedness. Our senior secured notes rank senior to any subordinated indebtedness that we or such subsidiary guarantors may incur; they are effectively senior to our and such subsidiary guarantors' existing and future unsecured indebtedness and other liabilities to the extent of the value of the collateral securing the notes and the subsidiary guarantees; they are effectively subordinated to our and such subsidiary guarantors' obligations under our Credit Agreement to the extent of the value of the collateral securing borrowings thereunder; and they are structurally subordinated to all obligations of our non-guarantor subsidiaries.

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

In December 2016, we sold $750 million aggregate amount of Second Lien Notes, which will mature on January 1, 2022. We will pay interest on the Second Lien Notes semi-annually in arrears on January 1 and July 1 of each year, commencing on July 1, 2017. The net proceeds of the Second Lien Notes were used, after payment of fees and expenses, to repay indebtedness outstanding under our Credit Agreement and for general corporate purposes.

Senior Unsecured Notes

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

Covenants

Credit Agreement. Our Credit Agreement contains customary covenants for an asset-backed facility, including a minimum fixed charge coverage ratio to be met if the designated excess availability under the revolving credit facility falls below $100 million, as well as limits on debt, asset sales and prepayments of senior debt. The Credit Agreement also includes a provision, which we believe is customary in receivables-backed credit facilities, that gives our lenders the right to require that proceeds of collections of substantially all of our consolidated accounts receivable be applied directly to repay outstanding loans and other amounts that are due and payable under the Credit Agreement at any time that unused borrowing availability under the revolving credit facility is less than $100 million for three consecutive business days or if an event of default has occurred and is continuing thereunder. In that event, we would seek to re-borrow under the Credit Agreement to satisfy our operating cash requirements. Our ability to borrow under the Credit Agreement is subject to conditions that we believe are customary in revolving credit facilities, including that no events of default then exist.

Senior Secured Notes. The indentures governing our senior secured notes contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions or consolidate, merge or sell all or substantially all of our or their assets, other than in certain transactions between one or more of our wholly owned subsidiaries. These restrictions, however, are subject to a number of exceptions and qualifications. In particular, there are no restrictions on our ability or the ability of our subsidiaries to incur additional indebtedness, make restricted payments, pay dividends or make distributions in respect of capital stock, purchase or redeem capital stock, enter into transactions with affiliates or make advances to, or invest in, other entities (including unaffiliated entities). In addition, the indentures governing our senior secured notes contain a covenant that neither we nor any of our subsidiaries will incur secured debt, unless at the time of and after giving effect to the incurrence of such debt, the aggregate amount of all such secured debt (including the aggregate principal amount of senior secured notes outstanding at such time) does not exceed the amount that would cause the secured debt ratio (as defined in the indentures) to exceed 4.0 to 1.0; provided that the aggregate amount of all such debt secured by a lien on par to the lien securing the senior secured notes may not exceed the amount that would cause the secured debt ratio to exceed 3.0 to 1.0.

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

Future Maturities

Future long-term debt maturities and minimum operating lease payments as of December 31, 2016 are as follows:

		Years Ending December 31,					Later
	Total	2017	2018	2019	2020	2021	Years
Long-term debt, including capital lease obligations	$ 15,490	$ 192	$ 1,157	$ 1,694	$ 4,321	$ 1,958	$ 6,168
Long-term non-cancelable operating leases	$ 1,216	$ 215	$ 182	$ 156	$ 125	$ 102	$ 436

Rental expense under operating leases, including short-term leases, was $335 million, $292 million and $242 million in the years ended December 31, 2016, 2015 and 2014, respectively. Included in rental expense for each of these periods was sublease income of $13 million, $12 million and $9 million, respectively, which were recorded as a reduction to rental expense.

NOTE 7. GUARANTEES

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

At December 31, 2016, 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 $95 million. We had a total liability of $90 million recorded for these guarantees included in other current liabilities at December 31, 2016.

At December 31, 2016, 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 $26 million. Of the total, $14 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Consolidated Balance Sheet at December 31, 2016.

NOTE 8. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

We currently grant stock-based awards to our directors and key employees pursuant to our 2008 Stock Incentive Plan, which was approved by our shareholders at their 2008 annual meeting. At December 31, 2016, assuming outstanding Performance Restricted Stock Units for which performance has not yet been determined will achieve Target

performance, approximately 7.2 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units (6.2 million shares remain available if we assume Maximum performance for outstanding Performance Restricted Stock Units for which performance has not yet been determined). Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and time-based restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have longer vesting periods. In addition, we grant performance-based restricted stock units (and, in prior years, have granted performance-based options) that vest subject to the achievement of specified performance goals within a specified timeframe.

Our Consolidated Statement of Operations for the years ended December 31, 2016, 2015 and 2014 includes $60 million, $77 million and $51 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements ($38 million, $48 million and $32 million, respectively, after-tax). The table below shows certain stock option and restricted stock unit grants and other awards that comprise the stock-based compensation expense recorded in the year ended December 31, 2016. Compensation cost is measured by the fair value of the awards on their grant dates and is recognized over the requisite service period of the awards, whether or not the awards had any intrinsic value during the period.

Grant Date	Awards (In Thousands)	Exercise Price Per Share	Fair Value Per Share at Grant Date	Stock-Based Compensation Expense for Year Ended December 31, 2016 (In Millions)
Restricted Stock Units:				
May 13, 2016	90		21.92	2
March 10, 2016	658		25.50	5
February 25, 2015	1,400		45.63	21
August 25, 2014	526		59.90	5
February 26, 2014	1,268		44.12	19
June 13, 2013	318		47.13	3
Other grants				5
				$ 60

Prior to our shareholders approving the 2008 Stock Incentive Plan, we granted stock-based awards to our directors and employees pursuant to other plans. Stock options remain outstanding under those other plans, but no additional stock-based awards will be granted under them.

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

Stock Options

The following table summarizes stock option activity during the years ended December 31, 2016, 2015 and 2014:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding at December 31, 2013	3,308,111	$ 30.79		
Granted	—			
Exercised	(699,910)	33.53		
Forfeited/Expired	(624,052)	47.97		
Outstanding at December 31, 2014	1,984,149	$ 24.42		
Granted	—	—		
Exercised	(340,869)	29.85		
Forfeited/Expired	(36,438)	42.08		
Outstanding at December 31, 2015	1,606,842	$ 22.87		
Granted	—	—		
Exercised	(111,715)	17.88		
Forfeited/Expired	(59,206)	18.68		
Outstanding at December 31, 2016	**1,435,921**	**$ 22.87**	**$ 2**	**2.1 years**
Vested and expected to vest at December 31, 2016	**1,435,921**	**$ 22.87**	**$ 2**	**2.1 years**
Exercisable at December 31, 2016	**1,435,921**	**$ 22.87**	**$ 2**	**2.1 years**

There were 111,715 stock options exercised during the year ended December 31, 2016 with an aggregated intrinsic value of approximately $1 million, and 340,869 stock options exercised during the same period in 2015 with an aggregate intrinsic value of approximately $8 million. There were no stock options granted in the years ended December 31, 2016 or 2015.

The following table summarizes information about our outstanding stock options at December 31, 2016:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	172,219	2.2 years	$ 4.56	172,219	$ 4.56
$4.57 to $25.089	827,315	2.8 years	20.85	827,315	20.85
$25.09 to $32.569	182,000	0.2 years	26.40	182,000	26.40
$32.57 to $42.529	254,387	1.2 years	39.31	254,387	39.31
	1,435,921	**2.1 years**	**$ 22.87**	**1,435,921**	**$ 22.87**

As of December 31, 2016, approximately 96.1% of all our outstanding options were held by current employees and approximately 3.9% were held by former employees. Approximately 12% of our outstanding options were in-the-money, that is, they had exercise price less than the $14.84 market price of our common stock on December 31, 2016, and approximately 88% were out-of-the-money, that is, they had an exercise price of more than $14.84 as shown in the table below:

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	150,975	87.5 %	1,228,869	97.3 %	1,379,844	96.1 %
Former employees	21,544	12.5 %	34,533	2.7 %	56,077	3.9 %
Totals	**172,519**	**100.0 %**	**1,263,402**	**100.0 %**	**1,435,921**	**100.0 %**
% of all outstanding options	**12.0 %**		**88.0 %**		**100.0 %**	

Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2016, 2015 and 2014:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2013	2,707,222	$ 33.34
Granted	1,772,276	48.42
Vested	(1,009,927)	27.49
Forfeited	(169,851)	36.64
Unvested at December 31, 2014	3,299,720	$ 40.99
Granted	1,718,057	45.51
Vested	(1,210,159)	38.40
Forfeited	(180,386)	42.46
Unvested at December 31, 2015	3,627,232	$ 44.69
Granted	1,626,329	30.05
Vested	(1,644,616)	42.95
Forfeited	(434,412)	38.59
Unvested at December 31, 2016	**3,174,533**	**$ 38.75**

In the year ended December 31, 2016, we granted 737,493 restricted stock units subject to time-vesting of which 504,511 will vest and be settled ratably over a three-year period from the grant date, 57,139 will vest and be settled on the third anniversary of the grant date and 175,843 will vest and be settled on the fifth anniversary of the grant date. In addition, in May 2016, we made an annual grant of 90,105 restricted stock units to our non-employee directors for the 2016-2017 board service year, which units vested immediately and will settle in shares of our common stock on the third anniversary of the date of the grant. The Board of Directors appointed four new members, two in January 2016 and two in November 2016. We made initial grants totaling 13,190 restricted stock units to these directors, as well as prorated annual grants totaling 19,648 restricted stock units. Both the initial grants and the annual grants vested immediately, however the initial grants will not settle until the directors' separation from the Board, while the annual grants settle on the third anniversary of the grant date. In addition, we granted 474,443 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of specified three-year performance goals for the years 2016 to 2018. 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 474,443 units granted, depending on our level of achievement with respect to the performance goals. Moreover, in the year ended December 31, 2016, we granted 291,540 restricted stock units as a result of our level of achievement with respect to prior-year target performance goals.

In the year ended December 31, 2015, we granted 1,142,230 restricted stock units subject to time-vesting, of which 1,067,383 will vest and be settled ratably over a three-year period from the grant date and 31,000 will vest 100% on the fifth anniversary of the grant date. In addition, in May 2015, we made an annual grant of 43,847 restricted stock units to our non-employee directors for the 2015-2016 board service year, which units vested immediately and will settle in shares of our common stock on the third anniversary of the date of the grant. In March 2015, following the appointment of a new member of our Board of Directors, we made an initial grant of 1,311 restricted stock units to that director, which units vested immediately, but will not settle until her separation from the Board, as well as a prorated annual grant of 526 restricted stock units for the 2014-2015 board service year, which units vested immediately, but will not settle until the earlier of three years from the date of grant or her separation from the board. Also, we granted 306,968 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of a specified one-year performance goal for the year ending December 31, 2015. The performance-based restricted stock units will vest ratably over a three-year period from the grant date.

As of December 31, 2016, there were $66 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 1.9 years.

Employee Stock Purchase Plan

We have an employee stock purchase plan under which we are currently authorized to issue up to 5,062,500 shares of common stock to our eligible employees. As of December 31, 2016, there were approximately 3,853,179 shares available for issuance under our employee stock purchase plan. Under the terms of the plan, eligible employees may elect to have between 1% and 10% of their base earnings withheld each quarter to purchase shares of our common stock. Shares are purchased at a price equal to 95% of the closing price on the last day of the quarter. The plan requires a one-year holding period for all shares issued. The holding period does not apply upon termination of employment. Under the plan, no individual may purchase, in any year, shares with a fair market value in excess of $25,000. The plan is currently not considered to be compensatory.

We sold the following numbers of shares under our employee stock purchase plan in the years ended December 31, 2016, 2015 and 2014:

	Years Ended December 31,		
	2016	2015	2014
Number of shares	217,184	145,290	162,128
Weighted average price	$ 17.21	$ 43.96	$ 46.91

Employee Retirement Plans

Substantially all of our employees, upon qualification, are eligible to participate in one of our defined contribution 401(k) plans. Under the plans, employees may contribute a portion of their eligible compensation, and we match such contributions annually up to a maximum percentage for participants actively employed, as defined by the plan documents. Employer matching contributions will vary by plan. Plan expenses, primarily related to our contributions to the plan, were approximately $116 million, $105 million and $92 million for the years ended December 31, 2016, 2015 and 2014, respectively. Such amounts are reflected in salaries, wages and benefits in the accompanying Consolidated Statements of Operations.

We maintain three frozen non-qualified defined benefit pension plans ("SERPs") that provide supplemental retirement benefits to certain of our current and former executives. One of these SERPs was frozen during the year ended December 31, 2014. These plans are not funded, and plan obligations for these plans are paid from our working capital. Pension benefits are generally based on years of service and compensation. Upon completing the acquisition of Vanguard on October 1, 2013, we assumed a frozen qualified defined benefit plan ("DMC Pension Plan") covering substantially all of the employees of our Detroit market that were hired prior to June 1, 2003. The benefits paid under the DMC Pension Plan are primarily based on years of service and final average earnings. During the years ended December 31, 2016 and 2015, the Society of Actuaries issued new mortality improvement scales (MP-2016 and MP-2015, respectively), which we incorporated into the estimates of our defined benefit plan obligations at December 31, 2016 and 2015. These changes to our mortality assumptions decreased our projected benefit obligations as of December 31, 2016 and 2015 by approximately $20 million and $25 million, respectively. The following tables

summarize the balance sheet impact, as well as the benefit obligations, funded status and rate assumptions associated with the SERPs and the DMC Pension Plan based on actuarial valuations prepared as of December 31, 2016 and 2015:

	December 31,	
	2016	2015
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations[1]		
Beginning obligations	$ (1,455)	$ (1,559)
Service cost	(2)	(3)
Interest cost	(69)	(64)
Actuarial gain(loss)	(58)	96
Benefits paid	109	75
Ending obligations	(1,475)	(1,455)
Fair value of plans assets		
Beginning plan assets	815	898
Gain (loss) on plan assets	36	(36)
Employer contribution	25	8
Benefits paid	(90)	(55)
Ending plan assets	786	815
Funded status of plans	$ (689)	$ (640)
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (63)	$ (45)
Other long-term liability	$ (626)	$ (595)
Accumulated other comprehensive loss	$ 322	$ 261
SERP Assumptions:		
Discount rate	4.25 %	4.75 %
Compensation increase rate	3.00 %	3.00 %
Measurement date	December 31, 2016	December 31, 2015
DMC Pension Plan Assumptions:		
Discount rate	4.42 %	4.67
Compensation increase rate	Frozen	Frozen
Measurement date	December 31, 2016	December 31, 2015

(1) The accumulated benefit obligation at December 31, 2016 and 2015 was appraximately $1.461 billion and $1.443 billion, respectively.

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

	Years Ended December 31,		
	2016	2015	2014
Service costs	$ 2	$ 3	$ 3
Interest costs	69	64	66
Expected return on plan assets	(51)	(57)	(60)
Amortization of net actuarial loss	12	12	4
Net periodic benefit cost	$ 32	$ 22	$ 13
SERP Assumptions:			
Discount rate	4.75 %	4.25 %	5.00 %
Long-term rate of return on assets	n/a	n/a	n/a
Compensation increase rate	3.00 %	3.00 %	3.00 %
Measurement date	January 1, 2016	January 1, 2015	January 1, 2014
Census date	January 1, 2016	January 1, 2015	January 1, 2014
DMC Pension Plan Assumptions:			
Discount rate	4.67 %	4.16 %	5.18 %
Long-term rate of return on assets	6.50 %	6.50 %	7.00 %
Compensation increase rate	Frozen	Frozen	Frozen
Measurement date	January 1, 2016	January 1, 2015	January 1, 2014
Census date	January 1, 2016	January 1, 2015	January 1, 2014

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

We recorded gain/(loss) adjustments of $(61) million, $15 million and ($254) million in other comprehensive income (loss) in the years ended December 31, 2016, 2015 and 2014, respectively, to recognize changes in the funded status of our SERPs and the DMC Pension Plan. Changes in the funded status are recorded as a direct increase or decrease to shareholders' equity through accumulated other comprehensive loss. Net actuarial gains/(losses) of $(73) million, $3 million and ($258) million during the years ended December 31, 2016, 2015 and 2014, respectively, and the amortization of net actuarial loss of $12 million, $12 million and $4 million for the years ended December 31, 2016, 2015 and 2014, respectively, were recognized in other comprehensive income (loss). Cumulative net actuarial losses of $322 million, $261 million and $276 million as of December 31, 2016, 2015 and 2014, respectively, and unrecognized prior service costs of less than $1 million as of each of the years ended December 31, 2016, 2015 and 2014, have not yet been recognized as components of net periodic benefit costs.

To develop the expected long-term rate of return on plan assets assumption, the DMC Pension Plan considers the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns on each asset class. The expected return for each asset class is then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. The weighted-average asset allocations by asset category as of December 31, 2016, were as follows:

Asset Category	Target	Actual
Cash and cash equivalents	6 %	7 %
United States government obligations	1 %	1 %
Equity securities	50 %	49 %
Debt Securities	43 %	43 %

The DMC Pension Plan assets are invested in separately managed portfolios using investment management firms. The objective for all asset categories is to maximize total return without assuming undue risk exposure. The DMC Pension Plan maintains a well-diversified asset allocation that best meets these objectives. The DMC Pension Plan assets are largely comprised of equity securities, which include companies with various market capitalization sizes in addition to international and convertible securities. Cash and cash equivalents are comprised of money market funds. Debt securities include domestic and foreign government obligations, corporate bonds, and mortgage-backed securities. Under

the investment policy of the DMC Pension Plan, investments in derivative securities are not permitted for the sole purpose of speculating on the direction of market interest rates. Included in this prohibition are leveraging, shorting, swaps, futures, options, forwards, and similar strategies.

In each investment account, the DMC Pension Plan investment managers are responsible to monitor and react to economic indicators, such as gross domestic product, consumer price index and U.S. monetary policy that may affect the performance of their account. The performance of all managers and the aggregate asset allocation are formally reviewed on a quarterly basis, with a rebalancing of the asset allocation occurring at least once a year. The current asset allocation objective is to maintain a certain percentage with each class allowing for a 10% deviation from the target.

The following tables summarize the DMC Pension Plan assets measured at fair value on a recurring basis as of December 31, 2016 and 2015, aggregated by the level in the fair value hierarchy within which those measurements are determined. Fair value methodologies for Level 1, Level 2 and Level 3 are consistent with the inputs described in Note 18.

	December 31, 2016	(Level 1)	(Level 2)	(Level 3)
Cash and cash equivalents	$ 60	$ 60	$ —	$ —
United States government obligations	5	5	—	—
Fixed Income funds	335	335	—	—
Equity securities	386	386	—	—
	$ 786	$ 786	$ —	$ —

	December 31, 2015	(Level 1)	(Level 2)	(Level 3)
Cash and cash equivalents	$ 44	$ 44	$ —	$ —
United States government obligations	5	5	—	—
Fixed Income funds	354	354	—	—
Equity securities	412	412	—	—
	$ 815	$ 815	$ —	$ —

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

		Years Ending December 31,					
	Total	2017	2018	2019	2020	2021	Five Years Thereafter
Estimated benefit payments	$ 941	$ 85	$ 88	$ 91	$ 93	$ 95	$ 489

The SERP and DMC Pension Plan obligations of $689 million at December 31, 2016 are classified in the accompanying Consolidated Balance Sheet as an other current liability ($63 million) and defined benefit plan obligations ($626 million) based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately $62 million for the year ending December 31, 2017.

NOTE 9. PROPERTY AND EQUIPMENT

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

	December 31,	
	2016	2015
Land	$ 667	$ 680
Buildings and improvements	7,277	7,041
Construction in progress	339	191
Equipment	4,744	4,326
	13,027	12,238
Accumulated depreciation and amortization	(4,974)	(4,323)
Net property and equipment	**$ 8,053**	**$ 7,915**

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

NOTE 10. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying Consolidated Balance Sheets as of December 31, 2016 and 2015:

	2016	2015
Hospital Operations and other		
As of January 1:		
Goodwill	$ 5,552	$ 5,642
Accumulated impairment losses	(2,430)	(2,430)
Total	3,122	3,212
Goodwill acquired during the year and purchase price allocation adjustments	251	100
Goodwill allocated to assets held for sale	—	(190)
Total	**$ 3,373**	**$ 3,122**
As of December 31:		
Goodwill	$ 5,803	$ 5,552
Accumulated impairment losses	(2,430)	(2,430)
Total	**$ 3,373**	**$ 3,122**
Ambulatory Care		
As of January 1:		
Goodwill	$ 3,243	$ 95
Accumulated impairment losses	—	—
Total	3,243	95
Goodwill acquired during the year and purchase price allocation adjustments	236	3,161
Impact of foreign currency translation	(32)	(13)
Total	**$ 3,447**	**$ 3,243**
As of December 31:		
Goodwill	$ 3,447	$ 3,243
Accumulated impairment losses	—	—
Total	**$ 3,447**	**$ 3,243**

	2016	2015
Conifer		
As of January 1:		
Goodwill	$ 605	$ 606
Accumulated impairment losses	—	—
Total	605	606
Goodwill acquired during the year and purchase price allocation adjustments	—	(1)
Total	**$ 605**	**$ 605**
As of December 31:		
Goodwill	$ 605	$ 605
Accumulated impairment losses	—	—
Total	**$ 605**	**$ 605**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of December 31, 2016 and 2015:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2016:			
Capitalized software costs	$ 1,562	$ (676)	$ 886
Trade names	106	—	106
Contracts	845	(43)	802
Other	104	(53)	51
Total	**$ 2,617**	**$ (772)**	**$ 1,845**
At December 31, 2015:			
Capitalized software costs	$ 1,456	$ (594)	$ 862
Trade Names	106	—	106
Contracts	653	(26)	627
Other	119	(39)	80
Total	**$ 2,334**	**$ (659)**	**$ 1,675**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2016 is as follows:

		Years Ending December 31,					
	Total	2017	2018	2019	2020	2021	Later Years
Amortization of intangible assets	$ 1,190	$ 186	$ 171	$ 147	$ 123	$ 86	$ 477

NOTE 11. INVESTMENTS AND OTHER ASSETS

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

	December 31,	
	2016	2015
Marketable debt securities	$ 49	$ 59
Equity investments in unconsolidated healthcare entities	935	817
Total investments	984	876
Cash surrender value of life insurance policies	28	28
Long-term deposits	34	36
Land held for expansion, long-term receivables and other assets	204	235
Investments and other assets	**$ 1,250**	**$ 1,175**

Our policy is to classify investments that may be needed for cash requirements as "available-for-sale." In doing so, the carrying values of the shares and debt instruments are adjusted at the end of each accounting period to their market values through a credit or charge to other comprehensive income (loss), net of taxes. At both December 31, 2016 and 2015, there were approximately $1 million of accumulated unrealized losses on these investments.

NOTE 12. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

	December 31,	
	2016	2015
Adjustments for defined benefit plans	$ (205)	$ (169)
Foreign currency translation adjustments	(53)	5
Accumulated other comprehensive loss	**$ (258)**	**$ (164)**

The tax effect allocated to the adjustments for our defined benefit plans was approximately $18 million for the year ended December 31, 2016 and less than $1 million for the year ended December 31, 2015.

NOTE 13. 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, 2016 through March 31, 2017, we have coverage totaling $600 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million each for floods and earthquakes and a per-occurrence sub-limit of $200 million for windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and windstorms, the total $600 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for floods, California earthquakes and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Reserves

At December 31, 2016 and 2015, the aggregate current and long-term professional and general liability reserves in our accompanying Consolidated Balance Sheets were approximately $794 million and $755 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related

expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.25%, 2.09% and 1.97% at December 31, 2016, 2015 and 2014, respectively.

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

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of $281 million, $283 million and $232 million for the years ended December 31, 2016, 2015 and 2014, respectively.

NOTE 14. 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, as described below. 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. 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.

Resolution of Clinica de la Mama Qui Tam Action and Criminal Investigation

As previously disclosed, on September 30, 2016, the Company and certain of its subsidiaries, including Tenet HealthSystem Medical, Inc. ("THSMI"), Atlanta Medical Center, Inc. ("AMCI") and North Fulton Medical Center, Inc. ("NFMCI"), executed agreements with the U.S. Department of Justice ("DOJ") and others to resolve the Clinica de la Mama civil qui tam litigation and criminal investigation. In October 2016, AMCI and NFMCI pled guilty to conspiring to violate the federal anti-kickback statute and defraud the United States. In addition, we paid approximately $517 million, including interest costs, in monetary forfeitures and settlement payments to the DOJ and other state entities. As a result of the resolution agreements, the previously disclosed civil qui tam litigation captioned *United States of America, ex rel. Ralph D. Williams v. Health Management Associates, Inc., et al.*, which was filed in the U.S. District Court for the Middle District of Georgia, was dismissed.

As required by the resolution agreements, THSMI also entered into a Non-Prosecution Agreement ("NPA") with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia (together, the "Offices"). Among other things, the NPA provides that if, during the term of the agreement, THSMI commits any felony under federal law, or if the Company commits any felony related to the federal anti-kickback statute, or if THSMI or the Company fail to cooperate or otherwise fail to fulfill the obligations set forth in the NPA, then THSMI, the Company and their affiliates shall be subject to prosecution for any federal criminal violation of which the Offices have knowledge,

including, but not limited to, the conduct described in the NPA. The Offices have sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution.

Pursuant to the NPA, on February 1, 2017, we retained two independent co-monitors (the "Monitor"), who are partners in a national law firm, to assess, oversee and monitor the Company's compliance with its obligations under the NPA. The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained); however, the Offices have the right to extend or shorten the term of the NPA under certain conditions.

For additional information regarding the foregoing matters, we refer you to the Company's Form 8-K filed on October 3, 2016, which summarizes the terms and conditions, and includes copies, of the resolution agreements.

Shareholder Litigation

On October 7, 2016, a purported shareholder of the Company's common stock filed a complaint in the U.S. District Court for the Central District of California against the Company and several current and former executive officers in a matter captioned *Pennington v. Tenet Healthcare Corporation, et al.* The plaintiff is seeking class certification on behalf of all persons who acquired the Company's securities between February 28, 2012 and October 3, 2016. On October 10, 2016, a second purported shareholder filed a complaint in the U.S. District Court for the Northern District of Texas (Dallas Division) against the Company and two current executive officers in a matter captioned *Yamany v. Tenet Healthcare Corporation, et al.* The plaintiff in this case is seeking class certification on behalf of all persons who acquired the Company's securities between February 26, 2013 and September 30, 2016. Both complaints allege that false or misleading statements or omissions concerning the Company's financial performance and compliance policies, specifically with respect to the Clinica de la Mama matters described above, caused the price of the Company's common stock to be artificially inflated. On February 10, 2017, the judge in the *Yamany* matter entered an order consolidating the cases in the Northern District of Texas (Dallas Division) and appointing four lead plaintiffs. The case is now captioned *In re Tenet Healthcare Corporation Securities Litigation.* Plaintiffs have until April 11, 2017 to file an amended and consolidated complaint.

On November 23, 2016, December 20, 2016 and January 23, 2017, three purported shareholders of the Company's common stock filed separate shareholder derivative lawsuits on behalf of the Company against current and former officers and directors. The complaints generally track the allegations in the securities class action complaints described above and claim that the plaintiffs did not make demand on the current directors to bring the lawsuits because such a demand would have been futile. On January 30, 2017, the judge in the matter captioned *Stewart, derivatively on behalf of Tenet Healthcare Corporation* entered an order consolidating that case with the matter captioned *City of Warren Police and Fire Retirement System, derivatively on behalf of Tenet Healthcare Corporation*, both of which were filed in Dallas County District Court, and appointing lead counsel and liaison counsel for plaintiffs. The consolidated case is now captioned *In re Tenet Healthcare Corporation Shareholder Derivative Litigation.* On February 23, 2017, the plaintiffs filed a Verified Consolidated Shareholder Derivative Petition. The third matter, filed in the U.S. District Court for the Northern District of Texas, is captioned *Horwitz, derivatively on behalf of Tenet Healthcare Corporation.* The Company intends to vigorously defend against the allegations in the purported shareholder class actions and shareholder derivative lawsuits.

Antitrust Class Action Lawsuit Filed by Registered Nurses in San Antonio

In *Maderazo, et al. v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al.*, filed in June 2006 in the U.S. District Court for the Western District of Texas, a purported class of registered nurses employed by three unaffiliated San Antonio-area hospital systems allege those hospital systems, including Baptist Health System, and other unidentified San Antonio regional hospitals violated Section §1 of the federal Sherman Act by conspiring to depress nurses' compensation and exchanging compensation-related information among themselves in a manner that reduced competition and suppressed the wages paid to such nurses. The suit seeks unspecified damages (subject to trebling under federal law), interest, costs and attorneys' fees. The case had been stayed since 2008; however, in July 2015, the court lifted the stay and re-opened discovery. We will continue to seek to defeat class certification and vigorously defend ourselves against the plaintiffs' allegations. It remains impossible at this time to predict the outcome of these proceedings with any certainty; however, we believe that the ultimate resolution of this matter will not have a material effect on our business, financial condition or results of operations.

Ordinary Course Matters

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

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

The following table presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the years ended December 31, 2016, 2015 and 2014:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2016					
Continuing operations	$ 299	$ 293	$ (582)	$ 2	$ 12
Discontinued operations	—	—	—	—	—
	$ 299	$ 293	$ (582)	$ 2	$ 12
Year Ended December 31, 2015					
Continuing operations	$ 73	$ 291	$ (72)	$ 7	$ 299
Discontinued operations	10	(8)	(2)	—	—
	$ 83	$ 283	$ (74)	$ 7	$ 299
Year Ended December 31, 2014					
Continuing operations	$ 64	$ 25	$ (16)	$ —	$ 73
Discontinued operations	6	18	(14)	—	10
	$ 70	$ 43	$ (30)	$ —	$ 83

For the years ended December 31, 2016, 2015 and 2014, we recorded net costs of $293 million, $283 million and $43 million, respectively, in connection with significant legal proceedings and governmental reviews.

NOTE 15. REDEEMABLE NONCONTROLLING INTEREST IN EQUITY OF CONSOLIDATED SUBSIDIARIES

In October 2015, we formed a new joint venture with Baptist Health System, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership interest in the joint venture, and we manage the network's operations. Baptist Health System contributed four hospitals—Citizens Baptist Medical Center, Princeton Baptist Medical Center, Shelby Baptist Medical Center and Walker Baptist Medical Center—to the joint venture, and we contributed Brookwood Medical Center. The network also includes each contributed hospital's related businesses. We paid approximately $184 million to align the respective valuations of the assets contributed to the joint venture. The joint venture's operating agreement includes a put option that the minority owners may exercise on their respective noncontrolling interest upon the occurrence of certain specified events. The redemption value is calculated using a fair market value analysis. As a result of this transaction, we recorded approximately $322 million of redeemable noncontrolling interests.

In August 2015, we formed a joint venture with Dignity Health and Ascension Health to own and operate Carondelet Health Network (the "Carondelet JV") based in Tucson, Arizona. We own a 60% controlling interest in the new

joint venture and manage the operations of the network. Affiliates of Dignity Health and Ascension Health (the "minority owners") own the remaining 40% noncontrolling interest in the Carondelet JV. The joint venture's operating agreement includes a put option that the minority owners may exercise on their respective noncontrolling interest on September 1, 2025. The redemption value is calculated using a fair market value analysis. As a result of this transaction, we recorded approximately $68 million of redeemable noncontrolling interests.

In June 2015, we formed a new joint venture by combining our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI. In connection with the formation of the USPI joint venture, we entered into a stockholders agreement pursuant to which we and our joint venture partners agreed to certain rights and obligations with respect to the governance of the joint venture.

As part of the USPI transaction, we also entered into a put/call agreement (the "Put/Call Agreement") that contains put and call options with respect to the equity interests in the joint venture held by our joint venture partners. Each year starting in 2016, our joint venture partners must put to us at least 12.5%, and may put up to 25%, of the equity held by them in the joint venture immediately after the closing. In each year that our joint venture partners are to deliver a put and do not put the full 25% of the USPI joint venture's shares allowable, we may call the difference between the number of shares our joint venture partners put and the maximum number of shares they could have put that year. In addition, the Put/Call Agreement contains certain other call options pursuant to which we will have the ability to acquire all of the ownership interests from our joint venture partners controlled by Welsh, Carson, Anderson & Stowe ("Welsh Carson") between 2018 and 2020. In the event of a put by our joint venture partners controlled by Welsh Carson, we will have the ability to choose whether to settle the purchase price in cash or shares of our common stock and, in the event of a call by us, our joint venture partners controlled by Welsh Carson will have the ability to choose whether to settle the purchase price in cash or shares of our common stock.

In addition, we entered into a separate put call agreement (the "Baylor Put/Call Agreement") with Baylor University Medical Center ("Baylor") that contains put and call options with respect to the equity interests in the USPI joint venture held by Baylor (3.01% at December 31, 2016). Each year starting in 2021, Baylor may put up to one-third of their total shares held as of January 1, 2017 in the joint venture. In each year that Baylor does not put the full 33.3% of the USPI joint venture's shares allowable, we may call the difference between the number of shares Baylor put and the maximum number of shares they could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of Baylor's ownership interest by 2024. We have the ability to choose whether to settle the purchase price for the Baylor put/call in cash or shares of our common stock.

Based on the nature of these put/call structures, the minority shareholders' interests in the USPI joint venture is classified as redeemable noncontrolling interests in our Consolidated Balance Sheet at December 31, 2015. As a result of this transaction, we recorded approximately $1.48 billion of redeemable noncontrolling interests. In January 2016, Welsh, Carson, Anderson & Stowe, on behalf of our joint venture partners, delivered a put notice for the minimum number of shares they were required to put to us in 2016 according to the Put/Call Agreement. In April 2016, we paid approximately $127 million to purchase these shares, which increased our ownership interest in the USPI joint venture to approximately 56.3%. In January 2017, Welsh, Carson, Anderson & Stowe, on behalf of our joint venture partners, delivered a put notice for the minimum number of shares they are required to put to us in 2017 according to the Put/Call Agreement. The estimated amount we will pay to repurchase these shares, which represent a 6.25% interest in our USPI joint venture, is between $159 million and $170 million.

When we acquired Vanguard Health Systems, Inc. ("Vanguard") in October 2013, we obtained a 51% controlling interest in a limited liability company that held the assets and liabilities of Valley Baptist Health System ("Valley Baptist"), which consists of two hospitals in Brownsville and Harlingen, Texas. The remaining 49% noncontrolling interest in the joint venture was held by the former owner of Valley Baptist (the "seller"). The joint venture operating agreement included a put option that would allow the seller to require us to purchase all or a portion of the seller's remaining noncontrolling interest in the limited liability company at certain specified time periods. In connection with the seller's exercise and the settlement of the put option, we acquired the remaining 49% noncontrolling interest from the seller on February 11, 2015 in exchange for approximately $254 million in cash, which was applied to and reduced our redeemable noncontrolling interests, with the difference between the payment and the carrying value of approximately $270 million recorded as additional paid-in capital. The redemption value of the put option was calculated pursuant to the terms of the operating

agreement based on the operating results and the debt of the joint venture. As a result, we now own 100% of Valley Baptist.

In January 2015, Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 90 CHI hospitals through 2032. At that time, CHI increased its minority ownership position in Conifer's principal operating subsidiary, Conifer Health Solutions, LLC, to approximately 23.8%, resulting in an increase in our redeemable noncontrolling interests of approximately $47 million.

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the years ended 2016 and 2015:

	December 31,	
	2016	2015
Balances at beginning of period	**$ 2,266**	**$ 401**
Net income	230	166
Distributions paid to noncontrolling interests	(105)	(60)
Purchase accounting adjustments	(47)	—
Purchases and sales of businesses and noncontrolling interests, net	49	1,759
Balances at end of period	**$ 2,393**	**$ 2,266**

Our redeemable noncontrolling interests balances at December 31, 2016 and 2015 in the table above were comprised of $520 million and $463 million, respectively, from our Hospital Operations and other segment, $1.715 billion and $1.698 billion, respectively, from our Ambulatory Care segment, and $158 million and $105 million, respectively, from our Conifer segment. Our net income attributable to redeemable noncontrolling interests for the years ended December 31, 2016 and 2015, respectively, on our Consolidated Statements of Operations were comprised of $31 million and $31 million, respectively, from our Hospital Operations and other segment, $285 million and $138 million, respectively, from our Ambulatory Care segment, and $52 million and $49 million, respectively, from our Conifer segment.

NOTE 16. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2016, 2015 and 2014 consists of the following:

	Years Ended December 31,		
	2016	2015	2014
Current tax expense (benefit):			
Federal	$ 12	$ (2)	$ (12)
State	14	28	18
	26	26	6
Deferred tax expense (benefit):			
Federal	34	24	46
State	7	18	(3)
	41	42	43
	$ 67	**$ 68**	**$ 49**

A reconciliation between the amount of reported income tax expense (benefit) and the amount computed by multiplying income (loss) from continuing operations before income taxes by the statutory federal income tax rate is shown below. State income tax expense for the year ended December 31, 2016 includes $35 million of expense related to the write off of expired or worthless unutilized state net operating loss carryforwards for which a full valuation allowance had been provided in prior years. A corresponding tax benefit of $35 million is included for the year ended December 31, 2016 to reflect the reduction in the valuation allowance. Foreign pretax loss for the years ended December 31, 2016 and December 31, 2015 was $16 million and $4 million, respectively.

	Years Ended December 31,		
	2016	2015	2014
Tax expense at statutory federal rate of 35%	$ 87	$ 50	$ 52
State income taxes, net of federal income tax benefit	16	18	5
Expired state net operating losses, net of federal income tax benefit	35	11	34
Tax attributable to noncontrolling interests	(106)	(59)	(23)
Nondeductible goodwill	29	22	—
Nontaxable gains	(11)	(11)	—
Nondeductible litigation costs	37	44	—
Nondeductible acquisition costs	1	4	2
Nondeductible health insurance provider fee	2	2	3
Changes in valuation allowance	(25)	4	(20)
Change in tax contingency reserves, including interest	(9)	7	(2)
Amendment of prior-year tax returns	—	(17)	—
Prior-year provision to return adjustments and other changes in deferred taxes	12	(12)	(5)
Other items	(1)	5	3
	$ 67	$ 68	$ 49

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

	December 31, 2016		December 31, 2015	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ —	$ 683	$ —	$ 718
Reserves related to discontinued operations and restructuring charges	13	—	15	—
Receivables (doubtful accounts and adjustments)	231	—	185	—
Deferred gain on debt exchanges	—	21	—	32
Accruals for retained insurance risks	351	—	318	—
Intangible assets	—	548	—	366
Other long-term liabilities	141	—	141	—
Benefit plans	457	—	459	—
Other accrued liabilities	60	—	99	—
Investments and other assets	—	130	—	69
Net operating loss carryforwards	653	—	715	—
Stock-based compensation	45	—	40	—
Other items	118	23	54	6
	2,069	1,405	2,026	1,191
Valuation allowance	(72)	—	(96)	—
	$ 1,997	$ 1,405	$ 1,930	$ 1,191

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

	December 31,	
	2016	2015
Deferred income tax assets	$ 871	$ 776
Deferred tax liabilities	(279)	(37)
Net deferred tax asset	$ 592	$ 739

During the year ended December 31, 2016, we decreased the valuation allowance by $24 million primarily due to the expiration or worthlessness of unutilized state net operating loss carryovers. The remaining balance in the valuation allowance at December 31, 2016 is $72 million. During the year ended December 31, 2015, the valuation allowance increased by $9 million, $5 million due to the acquisition of USPI and $4 million due to changes in expected realizability of deferred tax assets. The balance in the valuation allowance as of December 31, 2015 was $96 million.

During the year ended December 31, 2014, the valuation allowance decreased by $20 million, primarily due to the expiration of unutilized state net operating loss carryovers.

We account for uncertain tax positions in accordance with ASC 740-10-25, which prescribes a comprehensive model for the financial statement recognition, measurement, presentation and disclosure of uncertain tax positions taken or expected to be taken in income tax returns. The table below summarizes the total changes in unrecognized tax benefits during the year ended December 31, 2016. The additions and reductions for tax positions include the impact of items for which the ultimate deductibility is highly certain, but for which there is uncertainty about the timing of such deductions. Such amounts include unrecognized tax benefits that have impacted deferred tax assets and liabilities at December 31, 2016, 2015 and 2014.

	Continuing Operations	Discontinued Operations	Total
Balance at December 31, 2013	$ 43	$ —	$ 43
Reductions for tax positions of prior years	(1)	—	(1)
Additions for current-year tax positions	1	—	1
Reductions due to a lapse of statute of limitations	(5)	—	(5)
Balance at December 31, 2014	$ 38	$ —	$ 38
Additions for prior-year tax positions	1	—	1
Additions for current-year tax positions	5	—	5
Reductions due to a lapse of statute of limitations	(4)	—	(4)
Balance at December 31, 2015	$ 40	$ —	$ 40
Additions for prior-year tax positions	2	—	2
Reductions for tax positions of prior years	—	—	—
Additions for current-year tax positions	—	—	—
Reductions due to a lapse of statute of limitations	(7)	—	(7)
Balance at December 31, 2016	$ 35	$ —	$ 35

The total amount of unrecognized tax benefits as of December 31, 2016 was $35 million, of which $32 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2016 includes a benefit of $9 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2015 was $40 million, of which $37 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2015 includes expense of $2 million in continuing operations attributable to an increase in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2014 was $38 million, of which $31 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2014 includes a benefit of $6 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects.

Our practice is to recognize interest and/or penalties related to income tax matters in income tax expense in our consolidated statements of operations. Approximately $1 million of interest and penalties related to accrued liabilities for uncertain tax positions related to continuing operations are included in the accompanying Consolidated Statement of Operations for the year ended December 31, 2016. Total accrued interest and penalties on unrecognized tax benefits as of December 31, 2016 were $4 million, all of which related to continuing operations.

The Internal Revenue Service ("IRS") has completed audits of our tax returns for all tax years ending on or before December 31, 2007, and of Vanguard's tax returns for fiscal years ending on or before October 1, 2013. All disputed issues with respect to these audits have been resolved and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007 and Vanguard's tax returns for fiscal years ended after October 1, 2013 remain subject to examination by the IRS. USPI tax returns for years ended after December 31, 2011 remain subject to audit.

As of December 31, 2016, approximately $5 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

At December 31, 2016, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax expiring in 2025 to 2034, (2) approximately $30 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $24 million expiring in 2023 through 2036, and (4) state NOL carryforwards of $3.0 billion expiring in 2017 through 2036 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $19 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs (see Note 2), the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

NOTE 17. EARNINGS (LOSS) PER COMMON SHARE

The following table is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for our continuing operations for the years ended December 31, 2016, 2015 and 2014. Net income available (loss attributable) is expressed in millions and weighted average shares are expressed in thousands.

	Net Income Available (Loss Attributable) to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Year Ended December 31, 2016			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (187)	99,321	$ (1.88)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	**$ (187)**	**99,321**	**$ (1.88)**
Year Ended December 31, 2015			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (142)	99,167	$ (1.43)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	**$ (142)**	**99,167**	**$ (1.43)**
Year Ended December 31, 2014			
Net income attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 34	97,801	$ 0.35
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,486	(0.01)
Net income attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 34**	**100,287**	**$ 0.34**

All potentially dilutive securities were excluded from the calculation of diluted earnings (loss) per share for the years ended December 31, 2016 and 2015 because we did not report income from continuing operations available to common shareholders in those periods. In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to common shareholders in the years ended December 31, 2016 and 2015, 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 1,421 and 2,380 for the years ended December 31, 2016 and 2015, respectively.

NOTE 18. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of December 31, 2016 and 2015. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices for similar assets, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

Investments	December 31, 2016	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 49	$ 23	$ 26	$ —
	$ 49	$ 23	$ 26	$ —

Investments	December 31, 2015	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 59	$ 24	$ 35	$ —
	$ 59	$ 24	$ 35	$ —

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

	December 31, 2016	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held and used	$ 163	$ —	$ 163	$ —
Other than temporarily impaired equity method investments	$ 27	$ —	$ 27	$ —

	December 31, 2015	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held and used	$ 45	$ —	$ 45	$ —

As described in Note 5, in the years ended December 31, 2016 and 2015, we recorded impairment charges in continuing operations of $54 million and $19 million, respectively, for the write-down of buildings, equipment and other long-lived assets to their estimated fair values. These impairment charges recorded in the 2016 period related to four of our hospitals, while the impairment charges recognized in the 2015 period related to two of our hospitals. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract related intangibles and capitalized software costs not associated with the hospitals described above, in the year ended December 31, 2016.

The fair value of our long-term debt (except for borrowings under the Credit Agreement) is based on quoted market prices (Level 1). The inputs used to establish the fair value of the borrowings outstanding under the Credit Agreement are considered to be Level 2 inputs, which include inputs other than quoted prices included in Level 1 that are observable, either directly or indirectly. At December 31, 2016 and 2015, the estimated fair value of our long-term debt was approximately 93.9% and 96.2%, respectively, of the carrying value of the debt.

NOTE 19. ACQUISITIONS

During the year ended December 31, 2016, we completed the transaction that allowed us to consolidate five microhospitals that were previously recorded as equity method investments. We also acquired majority interests in 28 ambulatory surgery centers (all of which are owned by our USPI joint venture) and various physician practices. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $117 million.

During the year ended December 31, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with USPI's short-stay surgical facility assets into a new joint venture. We also completed the acquisition of Aspen, a network of nine private hospitals and clinics in the United Kingdom. In addition, we began operating Hi-Desert Medical Center, which is a 59-bed acute care hospital in Joshua Tree, California, and its related healthcare facilities, including a 120-bed skilled nursing facility, an ambulatory surgery center and an imaging center, under a long-term lease agreement. Furthermore, we formed a new joint venture with Dignity Health and Ascension Health to own and operate Carondelet Health Network, which is comprised of three hospitals with over 900 licensed beds, related physician practices, ambulatory surgery, imaging and urgent care centers, and other affiliated

businesses, in Tucson and Nogales, Arizona. We also formed a new joint venture with Baptist Health Systems, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership in the joint venture, and manage the network's operations. The network has more than 1,700 licensed beds, nine outpatient centers, 68 physician clinics, delivering primarily and specialty care, and more than 7,000 employees and approximately 1,500 affiliated physicians. Additionally, we acquired majority interests in nine ambulatory surgery centers and purchased 35 urgent care centers (all of which are owned by our USPI joint venture), and various physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $940 million.

During the year ended December 31, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. We also acquired five ambulatory surgery centers, three urgent care centers, one diagnostic imaging center, SPi Healthcare, a provider of revenue cycle management, health information management and software solutions, and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $428 million.

We are required to allocate the purchase prices of acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocated over those fair values is recorded as goodwill. The purchase price allocations for certain acquisitions completed in 2016 is preliminary. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, other intangible assets and noncontrolling interests for some of our 2016 acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed. During the year ended December 31, 2016, we made adjustments to the purchase price allocations for businesses acquired in 2015 that increased goodwill by approximately $59 million and increased depreciation and amortization expense by approximately $7 million for our Hospital Operations and other segment. During the year ended December 31, 2016, we made adjustments to the purchase price allocations for businesses acquired in 2015 that decreased goodwill by approximately $36 million for our Ambulatory Care segment.

Preliminary or final purchase price allocations for all the acquisitions made during the years ended December 31, 2016 and 2015 are as follows:

	2016	2015	2014
Current assets	$ 51	$ 457	$ 34
Property and equipment	38	1,059	113
Other intangible assets	7	361	46
Goodwill	464	3,374	340
Other long-term assets	(56)	557	2
Current liabilities	(30)	(443)	(30)
Deferred taxes — long term	—	(128)	(18)
Other long-term liabilities	(15)	(2,146)	(23)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(190)	(1,974)	(21)
Noncontrolling interests	(119)	(147)	(15)
Cash paid, net of cash acquired	(117)	(940)	(428)
Gains on consolidations	$ 33	$ 30	$ —

The goodwill generated from these transactions, the majority of which will not be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. Of the total $464 million of goodwill recorded for acquisitions completed during the year ended December 31, 2016, $192 million was recorded in our Hospital Operations and other segment, and $272 million was recorded in our Ambulatory Care segment. Approximately $20 million, $45 million and $16 million in transaction costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2016, 2015 and 2014, respectively, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Consolidated Statements of Operations.

During the year ended December 31, 2016 and 2015, we recognized gains totaling $33 million and $30 million, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

Pro Forma Information – Unaudited

Effective June 16, 2015, we combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into the USPI joint venture. We refinanced approximately $1.5 billion of existing USPI debt, which was allocated to the joint venture through an intercompany loan, and paid approximately $424 million to align the respective valuations of the assets contributed to the joint venture. We also completed the Aspen acquisition for approximately $226 million.

The following table provides 2016 actual results compared to 2015 and 2014 pro forma information for Tenet as if the USPI joint venture and Aspen acquisition had occurred at the beginning of the year ended December 31, 2014. The net income of USPI for the December 31, 2015 was adjusted by $30 million to remove a nonrecurring loss on extinguishment of debt.

	Years Ended December 31,		
	2016	2015	2014
Net operating revenues	$ 19,621	$ 19,018	$ 17,423
Equity in earnings of unconsolidated affiliates	$ 131	$ 143	$ 129
Net loss attributable to common shareholders	$ (192)	$ (171)	$ (40)
Net loss per share attributable to common shareholders	$ (1.93)	$ (1.73)	$ (0.41)

NOTE 20. SEGMENT INFORMATION

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

Our Hospital Operations and other segment is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals, physician practices and health plans (certain of which are classified as held for sale as described in Note 4). We also own various related healthcare businesses. At December 31, 2016, our subsidiaries operated 79 hospitals, primarily serving urban and suburban communities in 12 states, and six health plans (certain of which are classified as held for sale, as described in Note 4), as well as hospital-based outpatient centers, freestanding emergency departments and freestanding urgent care centers.

Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our nine Aspen facilities in the United Kingdom. At December 31, 2016, our USPI joint venture had interests in 239 ambulatory surgery centers, 34 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 27 states.

Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities. At December 31, 2016, Conifer provided services to more than 800 Tenet and non-Tenet hospitals and other clients nationwide. In 2012, we entered into agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer. The pricing terms for the services provided by each party to the other under these contracts were based on estimated third-party pricing terms in effect at the time the agreements were signed.

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

	December 31, 2016	December 31, 2015
Assets:		
Hospital Operations and other	$ 17,871	$ 17,353
Ambulatory Care	5,722	5,159
Conifer	1,108	1,170
Total	$ 24,701	$ 23,682

	Years Ended December 31,		
	2016	2015	2014
Capital expenditures:			
Hospital Operations and other	$ 799	$ 786	$ 899
Ambulatory Care	51	28	9
Conifer	25	28	25
Total	$ 875	$ 842	$ 933
Net operating revenues:			
Hospital Operations and other	$ 16,904	$ 16,928	$ 15,681
Ambulatory Care	1,797	959	320
Conifer			
Tenet	651	666	591
Other customers	920	747	602
Total Conifer revenues	1,571	1,413	1,193
Intercompany eliminations	(651)	(666)	(591)
Total	$ 19,621	$ 18,634	$ 16,603
Equity in earnings of unconsolidated affiliates:			
Hospital Operations and other	$ 9	$ 16	$ 12
Ambulatory Care	122	83	—
Total	$ 131	$ 99	$ 12
Adjusted EBITDA:			
Hospital Operations and other	$ 1,521	$ 1,653	$ 1,651
Ambulatory Care	615	358	98
Conifer	277	265	203
Total	$ 2,413	$ 2,276	$ 1,952
Depreciation and amortization:			
Hospital Operations and other	$ 709	$ 702	$ 810
Ambulatory Care	91	46	14
Conifer	50	49	25
Total	$ 850	$ 797	$ 849
Adjusted EBITDA	$ 2,413	$ 2,276	$ 1,952
Depreciation and amortization	(850)	(797)	(849)
Impairment and restructuring charges, and acquisition-related costs	(202)	(318)	(153)
Litigation and investigation costs	(293)	(291)	(25)
Interest expense	(979)	(912)	(754)
Investment earnings (losses)	8	1	—
Loss from early extinguishment of debt	—	(1)	(24)
Gains on sales, consolidation and deconsolidation of facilities	151	186	—
Net income from continuing operations before income taxes	$ 248	$ 144	$ 147

NOTE 21. RECENT ACCOUNTING STANDARDS

Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). In August 2015, the FASB amended the guidance to defer the effective date of this standard by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. We are currently evaluating the requirements of the new standard to insure that we have processes, systems and internal controls in place to collect the necessary information to implement the standard, which will be effective for us beginning in 2018. Early adoption is permitted starting with annual periods beginning after December 31, 2016, but we do not plan to early adopt the new standard. It is our current intention to use a modified retrospective method of application to adopt ASU 2014-09.We will use a portfolio approach to apply the new model to classes of payers with similar characteristics and will likely revise the approach we use to analyze cash collection trends for certain classes of payers once the final portfolios are determined, including the selection of the appropriate collection look-back period. Adoption of ASU 2014-09 will result in changes to our presentation for and disclosure of revenue related to uninsured or underinsured patients. Currently, a significant portion of our provision for doubtful accounts relates to self-pay patients as well as co-pays and deductibles owed to us by patients with insurance in our Hospital Operations and other segment. Under ASU 2014-09, the estimated uncollectible amounts due from these patients will generally be considered a direct reduction to net operating revenues and, correspondingly, will result in a material reduction in the amounts presented separately as provision for doubtful accounts. While the adoption of ASU 2014-09 will have a material effect on the amounts presented in certain categories on our Consolidated Statements of Operations, we do not expect it to materially impact our results of operations.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)" ("ASU 2016-02"), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and current GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under current GAAP. Recognition of these assets and liabilities will have a material impact to our Consolidated Balance Sheet upon adoption. In transition, lessees and lessors are required to recognize and measure leases at the beginning of the earliest period presented using a modified retrospective approach, which includes a number of optional practical expedients. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2019.

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

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230) Classification of Certain Cash Receipts and Cash Payments" ("ASU 2016-15"), which applies to all entities that are required to present a statement of cash flows under Topic 230. ASU 2016-15 addresses the presentation and classification of cash flows related to (i) debt prepayment or debt extinguishment costs, (ii) settlement of zero-coupon debt instruments or other debt instruments with coupon interest rates that are insignificant in relation to the effective interest rate of the borrowing, (iii) contingent consideration payments made after a business combination, (iv) proceeds from the settlement of insurance claims, (v) proceeds from the settlement of corporate-owned life insurance policies (including bank-owned life insurance policies), (vi) distributions received from equity method investees, (vii) beneficial interests in securitization transactions, and (viii) separately identifiable cash flows and application of the predominance principle. The amendments

in ASU 2016-05 should be applied using a retrospective transition method to each period presented, unless it is impracticable. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2018.

In November 2016, the FASB issued ASU 2016-18, "Statement of Cash Flows (Topic 230) Restricted Cash" ("ASU 2016-18"), which applies to all entities that have restricted cash or restricted cash equivalents and are required to present a statement of cash flows under Topic 230. ASU 2016-18 requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The amendments in ASU 2016-18 do not provide a definition of restricted cash or restricted cash equivalents. The amendments in ASU 2016-18 should be applied using a retrospective transition method to each period presented. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2018.

NOTE 22. SUBSEQUENT EVENTS

On February 19, 2017, we purchased the land and improvements associated with our Palm Beach Gardens Medical Center, which we previously leased, for approximately $44 million.

SUPPLEMENTAL FINANCIAL INFORMATION

SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)

	Year Ended December 31, 2016			
	First	Second	Third	Fourth
Net operating revenues	$ 5,044	$ 4,868	$ 4,849	$ 4,860
Net loss attributable to Tenet Healthcare Corporation common shareholders	$ (59)	$ (46)	$ (8)	$ (79)
Net income	$ 34	$ 39	$ 80	$ 23
Net loss per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic	$ (0.60)	$ (0.46)	$ (0.08)	$ (0.79)
Diluted	$ (0.60)	$ (0.46)	$ (0.08)	$ (0.79)

	Year Ended December 31, 2015			
	First	Second	Third	Fourth
Net operating revenues	$ 4,424	$ 4,492	$ 4,692	$ 5,026
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ 47	$ (61)	$ (29)	$ (97)
Net income (loss)	$ 76	$ (28)	$ 28	$ 2
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic	$ 0.48	$ (0.61)	$ (0.29)	$ (0.98)
Diluted	$ 0.47	$ (0.61)	$ (0.29)	$ (0.98)

Quarterly operating results are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; 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 or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the 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.

We have completed our analysis of the systems of disclosure controls and procedures and internal control over financial reporting related to the USPI joint venture and Aspen transactions. Furthermore, we integrated our USPI joint venture and Aspen into our broader framework of controls as of December 31, 2016. There were no changes in our internal control over financial reporting during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Management's report on internal control over financial reporting is set forth on page 101 and is incorporated herein by reference. The independent registered public accounting firm that audited the financial statements included in this report has issued an attestation report on our internal control over financial reporting as set forth on page 102 herein.

ITEM 9B. OTHER INFORMATION

None.

PART III.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Certain information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K. Information concerning our executive officers appears under Item 1, Executive Officers, of Part I of this report, and information concerning our *Standards of Conduct*, by which all of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide appears under Item 1, Business — Compliance and Ethics, of Part I of this report.

ITEM 11. EXECUTIVE COMPENSATION

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

PART IV.

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The Consolidated Financial Statements and notes thereto can be found on pages 104 through 148.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 161).

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

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

The consolidated financial statements of Texas Health Ventures Group, L.L.C. and subsidiaries ("THVG"), which are included due to the significance of the equity in earnings of unconsolidated affiliates we recognized from our investment in THVG for the year ended December 31, 2016, can be found on pages F-1 through F-18.

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

EXHIBITS

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

(2) Plan of Acquisition, Reorganization, Arrangement, Liquidation or Succession

(a) Contribution and Purchase Agreement, dated March 23, 2015, by and among the Registrant, USPI Group Holdings, Inc., Ulysses JV Holding I L.P., Ulysses JV Holding II L.P. and BB Blue Holdings, Inc. (Incorporated by reference to Exhibit 2.1 to Registrant's Current Report on Form 8-K, dated and filed March 23, 2015)

(b) Put/Call Agreement, dated June 16, 2015, by and among the Registrant, USPI Group Holdings, Inc., Ulysses JV Holding I L.P., Ulysses JV Holding II L.P. and USPI Holding Company, Inc. (Incorporated by reference to Exhibit 2(b) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, filed August 3, 2015)

(3) Articles of Incorporation and Bylaws

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

(b) Certificate of Designation, Preferences, and Rights of Series A Junior Participating Preferred Stock, par value $0.15 per share, dated January 7, 2011 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

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

(d) Amended and Restated Bylaws of the Registrant, as amended and restated effective January 7, 2011 (Incorporated by reference to Exhibit 3.2 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(b) Third Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee, relating to 6⅞% Senior Notes due 2031 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(c) Twelfth Supplemental Indenture, dated as of August 17, 2010, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 8% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed August 17, 2010)

(d) Fourteenth Supplemental Indenture, dated as of November 21, 2011, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 6¼% Senior Secured Notes due 2018 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated November 21, 2011 and filed November 22, 2011)

(e) Fifteenth Supplemental Indenture, dated as of October 16, 2012, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 4¾% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(f) Sixteenth Supplemental Indenture, dated as of October 16, 2012, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 6¾% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(g) Seventeenth Supplemental Indenture, dated as of February 5, 2013, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 4½% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed February 5, 2013)

(h) Twentieth Supplemental Indenture, dated as of May 30, 2013, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 4⅜% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated May 30, 2013 and filed May 31, 2013)

(i) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(j) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(k) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8⅛% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(l) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8⅛% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(m) Twenty-Third Supplemental Indenture, dated as of March 10, 2014, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 5% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated March 7, 2014 and filed March 10, 2014)

(n) Twenty-Fourth Supplemental Indenture, dated as of September 29, 2014, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 5½% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K dated and filed September 29, 2014)

(o) Twenty-Sixth Supplemental Indenture, dated as of June 16, 2015, among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to Floating Rate Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed June 16, 2015)

(p) Indenture, dated as of June 16, 2015, between THC Escrow Corporation II and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6¾% Senior Notes due 2023 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed June 16, 2015)

(q) Supplemental Indenture, dated as of June 16, 2015, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6¾% Senior Notes due 2023 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated and filed June 16, 2015)

(r) Twenty-Eighth Supplemental Indenture, dated as of December 1, 2016, among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 7½% Senior Secured Second Lien Notes due 2022 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed December 1, 2016)

(10) Material Contracts

(a) Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein

(Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated October 19, 2010 and filed October 20, 2010)

(b) Amendment No. 1, dated as of November 29, 2011, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated November 29, 2011 and filed December 1, 2011)

(c) Amendment No. 2, dated as of January 23, 2014, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10(c) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2013, filed February 24, 2014)

(d) Amendment No. 3, dated as of December 4, 2015, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto and Citicorp USA, Inc., as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated December 4, 2015 and filed December 9, 2015)

(e) Letter of Credit Facility Agreement, dated as of March 7, 2014, among the Registrant, certain financial institutions party thereto from time to time as letter of credit participants and issuers, and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated March 7, 2014 and filed March 10, 2014)

(f) Amendment No. 1, dated as of September 15, 2016, to the Letter of Credit Facility Agreement, dated as of March 7, 2014, among the Registrant, certain financial institutions party thereto from time to time as letter of credit participants and issuers, and Barclays Bank PLC, as administrative agent (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated September 15, 2016 and filed September 16, 2016)

(g) Guaranty, dated as of March 7, 2014, among Barclays Bank PLC, as administrative agent and the guarantors party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K, dated March 7, 2014 and filed March 10, 2014)

(h) Stock Pledge Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgers party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated March 3, 2009 and filed March 5, 2009)

(i) First Amendment to Stock Pledge Agreement, dated as of May 8, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(h) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)

(j) Second Amendment to Stock Pledge Agreement, dated as of June 15, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated June 15, 2009 and filed June 16, 2009)

(k) Third Amendment to Stock Pledge Agreement, dated as of March 7, 2014, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)

(l) Fourth Amendment to Stock Pledge Agreement, dated as of March 23, 2015, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10(k) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)

(m) Collateral Trust Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgers party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K, dated March 3, 2009 and filed March 5, 2009)

(n) Exchange and Registration Rights Agreement, dated as of December 1, 2016, among the Registrant, certain of its subsidiaries and Barclays Capital Inc., as representative of the initial purchasers of the Notes named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated and filed December 1, 2016)

(o) Settlement Agreement among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the Department of Health and Human Services, the State of Georgia, the State of South Carolina, the Registrant, Tenet HealthSystem Medical, Inc., Tenet HealthSystem GB, Inc. n/k/a Atlanta Medical Center, Inc., North Fulton Medical Center, Inc., Tenet HealthSystem Spalding, Inc. n/k/a Spalding Regional Medical Center, Inc., and Hilton Head Health System, L.P., and Ralph D. Williams (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated September 30, 2016 and filed October 3, 2016)

(p) Non-Prosecution Agreement among Tenet HealthSystem Medical, Inc., the United States Department of Justice and the United States Attorney's Office for the Northern District of Georgia (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K dated September 30, 2016 and filed October 3, 2016)

(q) Support Agreement, dated January 18, 2016, by and among the Registrant, Glenview Capital Management, LLC, Glenview Capital Partners, L.P., Glenview Capital Master Fund, Ltd., Glenview Institutional Partners, L.P., Glenview Offshore Opportunity Master Fund, Ltd. and Glenview Capital Opportunity Fund, L.P. (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated January 18, 2016 and filed January 19, 2016)

(r) Letter Agreement, dated November 2, 2016, by and among Tenet Healthcare Corporation, Glenview Capital Management, LLC, Glenview Capital Management, LLC, Glenview Capital Partners, L.P., Glenview Capital Master Fund, Ltd., Glenview Institutional Partners, L.P., Glenview Offshore Opportunity Master Fund, Ltd. and Glenview Capital Opportunity Fund, L.P. (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated November 2, 2016 and filed November 4, 2016)

(s) Letter from the Registrant to Trevor Fetter, dated November 7, 2002 (Incorporated by reference to Exhibit 10(k) to Registrant's Transition Report on Form 10-K for the seven-month transition period ended December 31, 2002, filed May 15, 2003)*

(t) Letter from the Registrant to Trevor Fetter dated September 15, 2003 (Incorporated by reference to Exhibit 10(l) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, filed November 10, 2003)*

(u) Letter from the Registrant to Keith B. Pitts dated June 21, 2013 (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2013, filed February 24, 2014)*

(v) Letter from the Registrant to J. Eric Evans, dated March 22, 2016 (Incorporated by reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016, filed May 2, 2016)*

(w) Letter from the Registrant to Daniel J. Cancelmi, dated September 6, 2012 (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(x) Letter from the Registrant to Audrey Andrews, dated January 22, 2013 (Incorporated by reference to Exhibit 10(m) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2012, filed February 26, 2013)*

(y) Tenet Second Amended and Restated Executive Severance Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(e) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(z) Tenet Healthcare Corporation Ninth Amended and Restated Supplemental Executive Retirement Plan, as amended and restated effective November 30, 2015 (Incorporated by reference to Exhibit 10(u) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)*

(aa) Ninth Amended and Restated Tenet 2001 Deferred Compensation Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(g) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(bb) Fourth Amended and Restated Tenet 2006 Deferred Compensation Plan, as amended and restated effective November 30, 2015 (Incorporated by reference to Exhibit 10(w) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)*

(cc) Fifth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(i) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(dd) Form of Stock Award used to evidence grants of stock options and/or restricted units under the Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan (Incorporated by reference to Exhibit 10.3 to Registrant's Current Report on Form 8-K, dated February 14, 2006 and filed February 17, 2006)*

(ee) Sixth Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan, as amended and restated effective March 10, 2016 (Incorporated by reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016, filed August 1, 2016)*

(ff) Forms of Award used to evidence (i) initial grants of restricted stock units to directors, (ii) annual grants of restricted stock units to directors, (iii) grants of stock options to executives, and (iv) grants of restricted stock units to executives, all under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(aa) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2008, filed February 24, 2009)*

(gg) Award Agreement, dated June 13, 2013, used to evidence grant of performance-based restricted stock units to Trevor Fetter under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, filed August 6, 2013)*

(hh) Form of Award used to evidence grants of performance cash awards under the Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan and the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit (ee) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2009, filed February 23, 2010)*

(ii) Tenet Special RSU Deferral Plan (Incorporated by reference to Exhibit 10(d) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009, filed May 5, 2009)*

(jj) Second Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective May 9, 2012 (Incorporated by reference to Exhibit 10(k) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(kk) Sixth Amended and Restated Tenet Executive Retirement Account, as amended and restated effective November 30, 2015 (Incorporated by reference to Exhibit 10(ff) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2015, filed February 22, 2016)*

(ll) Form of Indemnification Agreement entered into with each of the Registrant's directors (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, filed November 1, 2005)

(21) Subsidiaries of the Registrant

(23) Consents

(a) Consent of Deloitte & Touche LLP

(b) Consent of PricewaterhouseCoopers LLP

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

(a) Certification of Trevor Fetter, Chief Executive Officer and Chairman of the Board of Directors

(b) Certification of Daniel J. Cancelmi, Chief Financial Officer

(32) Section 1350 Certifications of Trevor Fetter, Chief Executive Officer and Chairman of the Board of Directors, and Daniel J. Cancelmi, Chief Financial Officer

(101 INS) XBRL Instance Document

(101 SCH) XBRL Taxonomy Extension Schema Document

(101 CAL) XBRL Taxonomy Extension Calculation Linkbase Document

(101 DEF) XBRL Taxonomy Extension Definition Linkbase Document

(101 LAB) XBRL Taxonomy Extension Label Linkbase Document

(101 PRE) XBRL Taxonomy Extension Presentation Linkbase Document

---

* Management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: February 27, 2017 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Date: February 27, 2017 By: /s/ TREVOR FETTER
Trevor Fetter
Chief Executive Officer and Chairman of the Board of Directors
(Principal Executive Officer)

Date: February 27, 2017 By: /s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer
(Principal Financial Officer)

Date: February 27, 2017 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Date: February 27, 2017 By: /s/ JOHN P. BYRNES
John P. Byrnes
Director

Date: February 27, 2017 By: /s/ BRENDA J. GAINES
Brenda J. Gaines
Director

Date: February 27, 2017 By: /s/ KAREN M. GARRISON
Karen M. Garrison
Director

Date: February 27, 2017 By: /s/ EDWARD A. KANGAS
Edward A. Kangas
Director

Date: February 27, 2017 By: /s/ J. ROBERT KERREY
J. Robert Kerrey
Director

Date: February 27, 2017 By: /s/ FREDA C. LEWIS-HALL, M.D.
Freda C. Lewis-Hall, M.D.
Director

Date: February 27, 2017 By: /s/ RICHARD R. PETTINGILL
Richard R. Pettingill
Director

Date: February 27, 2017	By:	/s/ MATTHEW J. RIPPERGER Matthew J. Ripperger Director
Date: February 27, 2017	By:	/s/ RONALD A. RITTENMEYER Ronald A. Rittenmeyer Director
Date: February 27, 2017	By:	/s/ TAMMY ROMO Tammy Romo Director
Date: February 27, 2017	By:	/s/ RANDOLPH C. SIMPSON Randolph C. Simpson Director
Date: February 27, 2017	By:	/s/ JAMES A. UNRUH James A. Unruh Director
Date: February 27, 2017	By:	/s/ PETER M. WILVER Peter M. Wilver Director

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Additions Charged To: Costs and Expenses[1][2]	Deductions[3]	Other Items[4]	Balance at End of Period
Allowance for doubtful accounts:					
Year ended December 31, 2016	$ 887	$ 1,451	$ (1,307)	$ —	$ 1,031
Year ended December 31, 2015	$ 852	$ 1,480	$ (1,388)	$ (57)	$ 887
Year ended December 31, 2014	$ 589	$ 1,305	$ (1,042)	$ —	$ 852
Valuation allowance for deferred tax assets					
Year ended December 31, 2016	$ 96	$ (24)	$ —	$ —	$ 72
Year ended December 31, 2015	$ 87	$ 4	$ —	$ 5	$ 96
Year ended December 31, 2014	$ 107	$ (20)	$ —	$ —	$ 87

(1) Includes amounts recorded in discontinued operations.
(2) Before considering recoveries on accounts or notes previously written off.
(3) Accounts written off.
(4) Acquisition and divestiture activity.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

YEAR ENDED JUNE 30, 2016

CONTENTS

Independent Auditor's Report

To the Board of Managers
Texas Health Ventures Group, L.L.C.:

We have audited the accompanying consolidated financial statements of Texas Health Ventures Group, L.L.C. and its subsidiaries (the Company), which comprise the consolidated balance sheet as of June 30, 2016, and the related consolidated statements of income, of changes in equity, and of cash flows for the year then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Texas Health Ventures Group, L.L.C. and its subsidiaries at June 30, 2016, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

/s/ PricewaterhouseCoopers LLP
November 7, 2016

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEET – JUNE 30, 2016
(in thousands)

	2016
ASSETS	
CURRENT ASSETS:	
Cash	$ 14,602
Restricted cash	—
Funds due from United Surgical Partners, Inc.	70,776
Patient receivables, net of allowance for doubtful accounts of $14,952	80,612
Supplies	18,833
Prepaid and other current assets	5,784
Total current assets	190,607
PROPERTY AND EQUIPMENT, net (Note 2)	160,708
OTHER LONG-TERM ASSETS:	
Investments in unconsolidated affiliates (Note 3)	3,968
Goodwill and intangible assets, net (Note 5)	240,649
Other	178
Total assets	$ 596,110
LIABILITIES AND EQUITY	
CURRENT LIABILITIES:	
Accounts payable	$ 39,314
Accrued expenses and other	32,252
Current portion of long-term obligations (Note 6)	12,494
Total current liabilities	84,060
LONG-TERM OBLIGATIONS, NET OF CURRENT PORTION (Note 6)	138,924
OTHER LIABILITIES	13,678
Total liabilities	236,662
COMMITMENTS AND CONTINGENCIES (Notes 6, 7, 8 and 9)	
NONCONTROLLING INTERESTS - REDEEMABLE	89,927
EQUITY:	
Members' equity	246,433
Noncontrolling interests – nonredeemable	23,088
Total equity	269,521
Total liabilities and equity	$ 596,110

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF INCOME

FOR THE YEAR ENDED JUNE 30, 2016
(in thousands)

	2016
REVENUES:	
Net patient service revenue	$ 881,897
Other income (Note 8)	7,886
Total revenues	889,783
EQUITY IN EARNINGS OF UNCONSOLIDATED AFFILIATES (Note 4)	3,861
OPERATING EXPENSES:	
Salaries, benefits, and other employee costs	198,257
Medical services and supplies	220,279
Management and royalty fees (Note 8)	34,174
Professional fees	5,803
Purchased services	36,209
Other operating expenses	93,867
Provision for doubtful accounts	21,739
Impairment loss	5,667
Depreciation and amortization	29,091
Total operating expenses	645,086
Operating income	248,558
NONOPERATING INCOME (EXPENSES):	
Interest expense	(14,028)
Interest income (Note 8)	364
Other income (expense), net	(350)
Net income before income taxes	234,544
INCOME TAXES	(3,858)
Net income	230,686
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS – Redeemable	(117,018)
NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS – Nonredeemable	(4,958)
Net income attributable to THVG	$ 108,710

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED JUNE 30, 2016
(in thousands)

		Members' Equity			Noncontrolling Interests - Nonredeemable
	Equity	USP	BUMC	Members' Equity	
Balance at June 30, 2015	253,720	115,909	116,374	232,283	21,437
Net income	113,668	54,246	54,464	108,710	4,958
Distributions to members	(105,054)	(50,121)	(50,321)	(100,442)	(4,612)
Contributions from members	8,912	4,447	4,465	8,912	—
Purchase of noncontrolling interests	(811)	(400)	(401)	(801)	(10)
Sale of noncontrolling interests	(914)	(1,113)	(1,116)	(2,229)	1,315
Balance at June 30, 2016	$ 269,521	$ 122,968	$123,465	$ 246,433	$ 23,088

See accompanying notes to consolidated financial statements.

TEXAS HEALTH VENTURES GROUP, L.L.C. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED JUNE 30, 2016
(in thousands)

	2016
CASH FLOWS FROM OPERATING ACTIVITIES:	
Net income	$ 230,686
Adjustments to reconcile net income to net cash provided by operating activities:	
Provision for doubtful accounts	21,739
Depreciation and amortization	29,091
Amortization of debt issue costs	7
Equity in earnings of unconsolidated affiliates, net of distributions received	(232)
Loss on fixed asset impairment	5,667
Gain on sale of assets	(67)
Changes in operating assets and liabilities, net of effects from purchases of new businesses:	
Increase in patient receivables	(36,666)
Increase in supplies, prepaids, and other assets	(4,937)
Increase in accounts payable, accrued expenses, and other liabilities	13,348
Net cash provided by operating activities	258,636
CASH FLOWS FROM INVESTING ACTIVITIES:	
Purchases of new businesses and equity interests, net of cash received of $135	(9,171)
Purchases of property and equipment	(17,207)
Sale of property and equipment	160
Change in deposits and notes receivables	9
Change in funds due from United Surgical Partners, Inc.	(12,794)
Net cash used in investing activities	(39,003)
CASH FLOWS FROM FINANCING ACTIVITIES:	
Proceeds from debt obligations	$ 4,624
Payments on debt obligations	(14,186)
Distributions to noncontrolling interest owners	(114,380)
Purchases of noncontrolling interests	(3,861)
Sales of noncontrolling interests	2,272
Contribution from members	8,912
Distributions to members	(100,442)
Net cash used in financing activities	(217,061)
INCREASE IN CASH	2,572
CASH, beginning of period	12,030
CASH, end of period	$ 14,602
SUPPLEMENTAL INFORMATION:	
Cash paid for interest	$ 14,035
Cash paid for income taxes	$ 3,779
Noncash transactions:	
Assets acquired under capital leases	$ 3,232
Increase in accounts payable due to property and equipment received but not paid	$ 427
Restricted cash borrowed	$ —
Restricted cash used for purchases of equipment	$ 280
Restricted cash used for payments on debt obligations	$ 2,089

See accompanying notes to consolidated financial statements.

Section X
Attachment 21
Charity Care

Silver Cross Hospital

Silver Cross Hospital provided the following amounts of charity care in the past 3 years:

	FY 2014	FY 2015	FY 2016
Total Net Patient Revenue	$309,018,000	$323,175,000	$351,053,000
Amount of Charity Care (Charges)	$27,115,000	$19,647,000	$17,715,000
Cost of Charity Care	$8,071,000	$5,605,000	$5,024,000
Cost of Charity Care/Total Net Patient Ratio	2.6%	1.7%	1.4%

In total, Silver Cross Hospital provided nearly $37,000,000 in charity care and other community benefits in FY 2016.

USPI Facilities Located in Illinois

The charity care information for the USPI facilities located in Illinois is attached at ATTACHMENT 21.

IL FACILITIES- CHARITY/ INDIGENT CARE ANALYSIS- 2014 2015 2016

Fin Year	Line item	Chicago 25 East	Chicago Hinsdale	Chicago North Shore	Chicago River North	STL- Effingham	STL- Mt Vernon
CY 2014	**ASC cases**	**2,138**	**5,513**	**3,263**	**2,766**	**6,673**	**2,522**
	Cases per day	8.42	21.70	12.85	10.89	26.27	9.93
	REVENUE						
	Gross patient revenue	$23,322,957	$34,133,869	$29,140,082	$41,641,088	$55,875,143	$20,452,166
	Miscellaneous revenue	500	1,732	220	797	4,578	455
	Total gross revenue	23,323,457	34,135,600	29,140,302	41,641,885	55,879,721	20,452,622
	Provision for contractuals	19,192,157	25,064,107	23,407,831	33,489,839	41,065,096	15,049,525
	Other revenue deductions	948	439	206	0	12,871	1,171
		0.005%	0.002%	0.001%	0.000%	0.031%	0.008%
	Total revenue deductions	19,193,105	25,064,546	23,408,037	33,489,839	41,077,966	15,050,697
	Net revenue	4,130,352	9,071,054	5,732,265	8,152,046	14,801,754	5,401,925
Charity	Cases	1	6	2	2	18	2
	Gross Charge	11,356	41,553	17,620	34,333	128,935	23,187
	Provision for contractual	9,281	35,510	15,652	26,089	77,283	9,524
	Expected Net Revenue	2,075	6,042	1,968	8,243	51,652	13,663
	Charity/ Indigent W/O	948	2,427	206	827	12,896	1,171
	as % of Expected NR	45.7%	40.2%	10.5%	10.0%	25.0%	8.6%
	Net Revenue less Charity	1,127	3,616	1,762	7,416	38,756	12,492

0382

Attachment 21

Fin Year	Line item	Chicago 25 East	Chicago Hinsdale	Chicago North Shore	Chicago River North	STL- Effingham	STL- Mt Vernon
CY 2015	**Cases**	**1,786**	**5,838**	**3,482**	**2,701**	**7,071**	**2,746**
	Cases per day	7.03	22.98	13.71	10.63	27.84	10.81
	REVENUE						
	Gross patient revenue	$19,321,284	$36,840,814	$30,406,467	$39,649,987	$59,053,412	$22,764,329
	Miscellaneous revenue	2,695	2,343	740	1,112	33,384	2,015
	Total gross revenue	19,323,979	36,843,157	30,407,207	39,651,099	59,086,797	22,766,343
	Provision for contractuals	15,680,284	27,191,420	24,337,157	32,028,469	43,756,322	16,935,672
	Other revenue deductions	0	1,650	0	0	23,430	4,803
		0.000%	0.006%	0.000%	0.000%	0.054%	0.028%
	Total revenue deductions	15,680,284	27,193,070	24,337,157	32,028,469	43,779,752	16,940,475
	Net revenue	3,643,695	9,650,087	6,070,051	7,622,630	15,307,044	5,825,868
Charity	Cases	0	8	0	0	28	4
	Gross Charge	0	46,809	0	0	216,056	79,461
	Provision for contractual	0	38,377	0	0	155,091	63,949
	Expected Net Revenue	0	8,432	0	0	60,965	15,512
	Charity/ Indigent W/O	0	1,651	0	0	23,430	4,803
	as % of Expected NR	#DIV/0!	19.6%	#DIV/0!	#DIV/0!	38.4%	31.0%
	Net Revenue less Charity	0	6,782	0	0	37,534	10,709

Fin Year	Line item	Chicago 25 East	Chicago Hinsdale	Chicago North Shore	Chicago River North	STL-Effingham	STL- Mt Vernon
CY2016	**Cases**	**2,051**	**6,045**	**3,806**	**2,471**	**7,085**	**3,221**
	Cases per day	8.07	23.80	14.98	9.73	27.89	12.68
	REVENUE						
	Gross patient revenue	$21,409,428	$44,041,426	$34,076,821	$37,313,354	$58,768,594	$26,718,383
	Miscellaneous revenue	89	4,914	0	5,040	20,654	629
	Total gross revenue	21,409,517	44,046,340	34,076,821	37,318,393	58,789,248	26,719,011
	Provision for contractuals	17,215,477	33,387,339	27,615,383	30,430,171	43,606,578	20,061,426
	Other revenue deductions	944	967	392	0	27,257	22,819
		0.005%	0.003%	0.001%	0.000%	0.062%	0.114%
	Total revenue deductions	17,216,422	33,388,306	27,615,776	30,430,171	43,633,835	20,084,245
	Net revenue	4,193,095	10,658,034	6,461,045	6,888,222	15,155,412	6,634,766
Charity	Cases	1	3	2	0	23	2
	Gross Charge	9,882	18,586	27,420	0	152,603	47,556
	Provision for contractual	7,807	14,603	24,995	0	67,017	24,436
	Expected Net Revenue	2,075	3,983	2,425	0	85,586	23,119
	Charity/ Indigent W/O	944	967	392	0	26,401	22,819
	as % of Expected NR	45.5%	24.3%	16.2%	#DIV/0!	30.8%	98.7%
	Net Revenue less Charity	1,131	3,017	2,032	0	59,185	300

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	21-26
2	Site Ownership	27
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	28-29
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	30-32
5	Flood Plain Requirements	33
6	Historic Preservation Act Requirements	34
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
9	Cost Space Requirements	
10	Discontinuation	
11	Background of the Applicant	35-41
12	Purpose of the Project	
13	Alternatives to the Project	
	Service Specific:	
14	Neonatal Intensive Care Services	
15	Change of Ownership	42-380
	Financial and Economic Feasibility:	
16	Availability of Funds	
17	Financial Waiver	
18	Financial Viability	
19	Economic Feasibility	
20	Safety Net Impact Statement	
21	Charity Care Information	381-384

4832-9422-3431, v. 1