TENET HEALTHCARE CORP
Form 10-Q
August 06, 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Form 10-Q

Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the quarterly period ended June 30, 2018

OR

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

Commission File Number 1-7293

_____

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

_____

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

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

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

_____

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

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

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

Large accelerated filer x Accelerated filer ¨ Non-accelerated filer ¨

Smaller reporting company ¨ Emerging growth company ¨

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

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

At July 31, 2018, there were 102,397,428 shares of the Registrant’s common stock, $0.05 par value, outstanding.

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PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

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

	June 30, 2018	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$403	$611
Accounts receivable (less allowance for doubtful accounts of $898 at December 31, 2017)	2,483	2,616
Inventories of supplies, at cost	298	289
Income tax receivable	28	5
Assets held for sale	452	1,017
Other current assets	1,041	1,035
Total current assets	4,705	5,573
Investments and other assets	1,416	1,543
Deferred income taxes	348	455
Property and equipment, at cost, less accumulated depreciation and amortization ($5,018 at June 30, 2018 and $4,739 at December 31, 2017)	6,863	7,030
Goodwill	7,218	7,018
Other intangible assets, at cost, less accumulated amortization ($964 at June 30, 2018 and $883 at December 31, 2017)	1,793	1,766
Total assets	$22,343	$23,385
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$663	$146
Accounts payable	1,047	1,175
Accrued compensation and benefits	711	848
Professional and general liability reserves	230	200
Accrued interest payable	243	256
Liabilities held for sale	393	480
Other current liabilities	1,067	1,227
Total current liabilities	4,354	4,332
Long-term debt, net of current portion	14,204	14,791
Professional and general liability reserves	630	654
Defined benefit plan obligations	515	536
Deferred income taxes	36	36
Other long-term liabilities	599	631
Total liabilities	20,338	20,980
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,429	1,866
Equity:		
Shareholders’ equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 150,698,821 shares issued at June 30, 2018 and 149,384,952 shares issued at December 31, 2017	7	7

Additional paid-in capital	4,722	4,859
Accumulated other comprehensive loss	(243)	(204)
Accumulated deficit	(2,222)	(2,390)
Common stock in treasury, at cost, 48,397,605 shares at June 30, 2018 and 48,413,169 shares at December 31, 2017	(2,418)	(2,419)
Total shareholders' equity (deficit)	(154)	(147)
Noncontrolling interests	730	686
Total equity	576	539
Total liabilities and equity	$22,343	$23,385

See accompanying Notes to Condensed Consolidated Financial Statements.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Net operating revenues:				
Net operating revenues before provision for doubtful accounts		$5,173		$10,369
Less: Provision for doubtful accounts		371		754
Net operating revenues	$4,506	4,802	9,205	9,615
Equity in earnings of unconsolidated affiliates	39	28	64	57
Operating expenses:				
Salaries, wages and benefits	2,135	2,346	4,362	4,726
Supplies	748	780	1,522	1,545
Other operating expenses, net	1,027	1,159	2,087	2,346
Electronic health record incentives	—	(6)	(1)	(7)
Depreciation and amortization	194	222	398	443
Impairment and restructuring charges, and acquisition-related costs	30	41	77	74
Litigation and investigation costs	13	1	19	6
Net gains on sales, consolidation and deconsolidation of facilities	(8)	(23)	(118)	(38)
Operating income	406	310	923	577
Interest expense	(254)	(260)	(509)	(518)
Other non-operating expense, net	(1)	(5)	(2)	(10)
Loss from early extinguishment of debt	(1)	(26)	(2)	(26)
Income from continuing operations, before income taxes	150	19	410	23
Income tax benefit (expense)	(44)	12	(114)	45
Income from continuing operations, before discontinued operations	106	31	296	68
Discontinued operations:				
Income from operations	2	2	3	—
Income tax expense	—	(1)	—	—
Income from discontinued operations	2	1	3	—
Net income	108	32	299	68
Less: Net income available to noncontrolling interests	82	87	174	176
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$26	$(55)	$125	$(108)
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders				
Income (loss) from continuing operations, net of tax	$24	$(56)	$122	$(108)
Income from discontinued operations, net of tax	2	1	3	—
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$26	$(55)	$125	$(108)
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic				
Continuing operations	$0.23	$(0.56)	$1.20	$(1.08)
Discontinued operations	0.02	0.01	0.03	—
	$0.25	$(0.55)	$1.23	$(1.08)
Diluted				

Continuing operations	$0.23	$(0.56)	$1.18	$(1.08)
Discontinued operations	0.02	0.01	0.03	—
	$0.25	$(0.55)	$1.21	$(1.08)
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	102,147	100,612	101,770	100,306
Diluted	104,177	100,612	103,416	100,306

See accompanying Notes to Condensed Consolidated Financial Statements.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Net income	$108	$32	$299	$68
Other comprehensive income:				
Amortization of net actuarial loss included in other non-operating expense, net	4	4	8	8
Unrealized gains on securities held as available-for-sale	—	1	—	3
Foreign currency translation adjustments	(9)	6	(3)	9
Other comprehensive income (loss) before income taxes	(5)	11	5	20
Income tax benefit (expense) related to items of other comprehensive income	1	2	(1)	(4)
Total other comprehensive income (loss), net of tax	(4)	13	4	16
Comprehensive net income	104	45	303	84
Less: Comprehensive income available to noncontrolling interests	82	87	174	176
Comprehensive income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$22	$(42)	$129	$(92)

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions
(Unaudited)

	Six Months Ended June 30,	
	2018	2017
Net income	$299	$68
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	398	443
Provision for doubtful accounts	—	754
Deferred income tax expense (benefit)	108	(81)
Stock-based compensation expense	20	29
Impairment and restructuring charges, and acquisition-related costs	77	74
Litigation and investigation costs	19	6
Net gains on sales, consolidation and deconsolidation of facilities	(118)	(38)
Loss from early extinguishment of debt	2	26
Equity in earnings of unconsolidated affiliates, net of distributions received	10	4
Amortization of debt discount and debt issuance costs	22	22
Pre-tax income from discontinued operations	(3)	—
Other items, net	(1)	(25)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(13)	(673)
Inventories and other current assets	144	160
Income taxes	(18)	(7)
Accounts payable, accrued expenses and other current liabilities	(371)	(345)
Other long-term liabilities	(48)	48
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	(63)	(62)
Net cash used in operating activities from discontinued operations, excluding income taxes	(3)	(2)
Net cash provided by operating activities	461	401
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(268)	(348)
Purchases of businesses or joint venture interests, net of cash acquired	(89)	(26)
Proceeds from sales of facilities and other assets	481	74
Proceeds from sales of marketable securities, long-term investments and other assets	143	16
Purchases of equity investments	(37)	(2)
Other long-term assets	3	(12)
Other items, net	(8)	(10)
Net cash provided by (used in) investing activities	225	(308)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(360)	(100)
Proceeds from borrowings under credit facility	360	100
Repayments of other borrowings	(161)	(1,029)
Proceeds from other borrowings	14	837
Debt issuance costs	—	(29)
Distributions paid to noncontrolling interests	(140)	(123)
Proceeds from sales of noncontrolling interests	7	14
Purchases of noncontrolling interests	(642)	(5)

Proceeds from exercise of stock options and employee stock purchase plan	14	3
Other items, net	14	(2)
Net cash used in financing activities	(894)	(334)
Net decrease in cash and cash equivalents	(208)	(241)
Cash and cash equivalents at beginning of period	611	716
Cash and cash equivalents at end of period	$403	$475
Supplemental disclosures:		
Interest paid, net of capitalized interest	$(501)	$(468)
Income tax payments, net	$(21)	$(44)

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. At June 30, 2018, we operated 68 hospitals, 21 surgical hospitals and approximately 470 outpatient centers in the United States, as well as nine facilities in the United Kingdom, through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI"). 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.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2017 ("Annual Report"). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts).

Effective January 1, 2018, we adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09") using a modified retrospective method of application to all contracts existing on January 1, 2018. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. For our Hospital Operations and other and Ambulatory Care segments, the adoption of ASU 2014-09 resulted in changes to our presentation for and disclosure of revenue primarily related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding material reduction in the amounts presented separately as provision for doubtful accounts. For the six months ended June 30, 2018, we recorded approximately $713 million of implicit price concessions as a direct reduction of net operating revenues that would have been recorded as provision for doubtful accounts prior to the adoption of ASU 2014-09. At June 30, 2018, we recorded $420 million as a direct reduction of accounts receivable that would have been reflected as allowance for doubtful accounts prior to the adoption of ASU 2014-09. At January 1, 2018, we reclassified $171 million of revenues related to patients who were still receiving inpatient care in our facilities at that date from accounts receivable, less allowance for doubtful accounts, to contract assets, which are included in other current assets in the accompanying Condensed Consolidated Balance Sheet at June 30, 2018. The adoption of ASU 2014-09 also resulted in changes to our presentation and disclosure of customer contract assets and liabilities and the assessment of variable consideration under customer contracts, which are further discussed in Note 3.

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

comprehensive loss to accumulated deficit in the three months ended March 31, 2018.

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

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Also effective January 1, 2018, we adopted ASU 2016-15, "Statement of Cash Flows (Topic 230) Classification of Certain Cash Receipts and Cash Payments" and ASU 2016-18, "Statement of Cash Flows (Topic 230) Restricted Cash," both of which were applied using a retrospective transition method to each period presented. The adoption of these standards did not have any effect on our statements of cash flows.

Although the Condensed Consolidated Financial Statements and related notes within this document are unaudited, we believe all adjustments considered necessary for a fair presentation have been included and are of a normal recurring nature. In preparing our financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP"), we are required to make estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Operating results for the three and six month periods ended June 30, 2018 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated implicit price concessions; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; gains (losses) on sales, consolidation and deconsolidation of facilities; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains 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: changes in federal and state healthcare regulations; the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; hospital performance data on quality measures and patient satisfaction, as well as standard charges for our services; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

Translation of Foreign Currencies

The accounts of European Surgical Partners Limited ("Aspen") were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities were translated using the current rate of exchange at the balance sheet date. Results of operations were translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates are accumulated in shareholders'

equity.

Net Operating Revenues

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

We recognize net operating revenues in the period in which we satisfy our performance obligations under contracts by transferring our services to our customers. Net operating revenues are recognized in the amounts to which we expect to be entitled, which are the transaction prices allocated to the distinct services. Net operating revenues for our Hospital Operations and other and Ambulatory Care segments primarily consist of net patient service revenues, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our Compact with

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Uninsured Patients ("Compact") and other uninsured discount and charity programs. Net operating revenues for our Conifer segment primarily consist of revenues from providing revenue cycle management services to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

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

We determine performance obligations based on the nature of the services we provide. We recognize revenues for performance obligations satisfied over time based on actual charges incurred in relation to total expected charges. We believe that this method provides a faithful depiction of the transfer of services over the term of performance obligations based on the inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients in our hospitals receiving inpatient acute care services. We measure performance obligations from admission to the point when there are no further services required for the patient, which is generally the time of discharge. We recognize revenues for performance obligations satisfied at a point in time, which generally relate to patients receiving outpatient services, when: (1) services are provided; and (2) we do not believe the patient requires additional services.

Because our patient service performance obligations relate to contracts with a duration of less than one year, we have elected to apply the optional exemption provided in FASB Accounting Standards Codification ("ASC") 606-10-50-14(a) and, therefore, we are not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

We determine the transaction price based on gross charges for services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with our Compact, and implicit price concessions provided primarily to uninsured patients. We determine our estimates of contractual adjustments and discounts based on contractual agreements, our discount policies and historical experience. We determine our estimate of implicit price concessions based on our historical collection experience with these classes of patients using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. The financial statement effects of using this practical expedient are not materially different from an individual contract approach.

Gross charges are retail charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately paid and, therefore, are not displayed in our consolidated statements of operations. Hospitals are typically paid amounts that are negotiated with insurance companies or are set by the government. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts (such as stop-loss payments). Because Medicare requires that a hospital's gross charges be the same for all patients (regardless of payer category), gross charges are what hospitals charge all patients prior to the application of discounts and allowances.

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as Indirect Medical Education, Direct Graduate Medical

Education, disproportionate share hospital and bad debt expense reimbursement, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates we record could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. As a result, we record accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

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Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and our historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews and investigations.

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

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

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

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

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

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

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

At contract inception, Conifer assesses the services specified in its contracts with customers and identifies a performance obligation for each distinct contracted service. Conifer identifies the performance obligations and considers all the services provided under the contract. Conifer generally considers the following distinct services as separate performance obligations:
•revenue cycle management services;
•value-based care services;
•patient communication and engagement services;
•consulting services; and
•other client-defined projects.
Conifer's contracts generally consist of fixed-price, volume-based or contingency-based fees. Conifer's long-term contracts typically provide for Conifer to deliver recurring monthly services over a multi-year period. The contracts are typically priced such that Conifer's monthly fee to its customer represents the value obtained by the customer in the month for those services. Such multi-year service contracts may have upfront fees related to transition or integration work performed by Conifer to set up the delivery for the ongoing services. Such transition or integration work typically does not result in a separately identifiable obligation; thus, the fees and expenses related to such work are deferred and recognized over the life of the related contractual service period. Revenue for fixed-priced contracts is typically recognized at the time of billing unless evidence suggests that the revenue is earned or Conifer's obligations are fulfilled in a different pattern. Revenue for volume-based contracts is typically recognized as the services are being performed at the contractually billable rate, which is generally a percentage of collections or a percentage of client net patient revenue.

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 $403 million and $611 million at June 30, 2018 and December 31, 2017, respectively. At June 30, 2018 and December 31, 2017, our book overdrafts were approximately $256 million and $311 million, respectively, which were classified as accounts payable.

At June 30, 2018 and December 31, 2017, approximately $175 million and $179 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries, and approximately $43 million and $30 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our health plan-related businesses.

Also at June 30, 2018 and December 31, 2017, we had $76 million and $117 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $55 million and $79 million, respectively, were included in accounts payable.

During the six months ended June 30, 2018 and 2017, we entered into non-cancellable capital leases of approximately $50 million and $43 million, respectively, primarily for equipment.

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Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets at June 30, 2018 and December 31, 2017:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At June 30, 2018:			
Capitalized software costs	$ 1,688	$ (822)	$866
Trade names	102	—	102
Contracts	861	(68)	793
Other	106	(74)	32
Total	$ 2,757	$ (964)	$1,793

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2017:			
Capitalized software costs	$ 1,582	$ (754)	$828
Trade names	102	—	102
Contracts	859	(60)	799
Other	106	(69)	37
Total	$ 2,649	$ (883)	$1,766

Estimated future amortization of intangibles with finite useful lives at June 30, 2018 is as follows:

	Total	Six Months Ending December 31, 2018	Years Ending 2019	2020	2021	2022	Later Years
Amortization of intangible assets	$1,125	$78	$154	$126	$108	$ 97	$ 562

We recognized amortization expense of $89 million and $81 million in the accompanying Condensed Consolidated Statements of Operations for the six months ended June 30, 2018 and 2017, respectively.

Investments in Debt and Equity Securities

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

Subsequent to the adoption of ASU 2016-01 on January 1, 2018, we classify investments in debt securities as either available-for-sale, held-to-maturity or as part of a trading portfolio, but these classifications are no longer applicable to equity securities. At June 30, 2018, we had no significant investments in debt securities classified as either held-to-maturity or trading. We carry debt securities classified as available-for-sale at fair value. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determine that

a loss is other-than-temporary, at which point we would record a loss in our consolidated statements of operations. We carry equity securities at fair value, and we report their unrealized gains and losses in other non-operating expense, net, in our consolidated statements of operations. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Investments in Unconsolidated Affiliates

We control 232 of the facilities within our Ambulatory Care segment and, therefore, consolidate their results. We account for many of the facilities our Ambulatory Care segment operates (110 of 342 at June 30, 2018), as well as additional facilities in which our Hospital Operations and other segment holds ownership interests, under the equity method as investments in unconsolidated affiliates and report only our share of net income available to the investee as equity in earnings of unconsolidated affiliates in the accompanying Condensed Consolidated Statements of Operations. Summarized financial

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information for the equity method investees within our Ambulatory Care segment is included in the following table, as well as summarized financial information for the four North Texas hospitals in which we held minority interests that were operated by our Hospital Operations and other segment through the divestiture of these investments effective March 1, 2018. We recorded a gain of approximately $13 million in the six months ended June 30, 2018 due to the sales of our minority interests in these hospitals. For investments acquired during the reported periods, amounts reflect 100% of the investee's results beginning on the date of our acquisition of the investment.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Net operating revenues	$547	$600	$1,121	$1,184
Net income	$132	$118	$248	$233
Net income available to the investees	$89	$73	$160	$149

NOTE 2. ACCOUNTS RECEIVABLE

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

	June 30, 2018	December 31, 2017
Continuing operations:		
Patient accounts receivable	$2,370	$ 3,376
Allowance for doubtful accounts	—	(898)
Estimated future recoveries	110	132
Net cost reports and settlements payable and valuation allowances	1	4
	2,481	2,614
Discontinued operations	2	2
Accounts receivable	$2,483	$ 2,616

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

We also provide charity care to patients who are 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. The following table shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) of caring for our self-pay patients and charity care patients, as well as revenues attributable to Medicaid DSH and other supplemental revenues we recognized in the three and six months ended June 30, 2018 and 2017:

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	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Estimated costs for:				
Self-pay patients	$159	$160	$305	$320
Charity care patients	28	33	63	63
Total	$187	$193	$368	$383
Medicaid DSH and other supplemental revenues	$198	$164	$418	$322

At June 30, 2018, we had approximately $167 million and $259 million of receivables recorded in other current assets and investments and other assets, respectively, and approximately $59 million and $54 million of payables recorded in other current liabilities and other long-term liabilities, respectively, in the accompanying Condensed Consolidated Balance Sheet related to California's provider fee program. At December 31, 2017, we had approximately $312 million and $266 million of receivables recorded in other current assets and investments and other assets, respectively, and approximately $159 million and $49 million recorded in other current liabilities and other long-term liabilities, respectively, in the accompanying Condensed Consolidated Balance Sheet related to California's provider fee program.

NOTE 3. CONTRACT BALANCES

Hospital Operations and Other Segment

Under the provisions of ASU 2014-09, which we adopted effective January 1, 2018, amounts related to services provided to patients for which we have not billed and that do not meet the conditions of unconditional right to payment at the end of the reporting period are contract assets. For our Hospital Operations and other segment, our contract assets consist primarily of services that we have provided to patients who are still receiving inpatient care in our facilities at the end of the reporting period. Our Hospital Operations and other segment's contract assets are included in other current assets on the accompanying Condensed Consolidated Balance Sheet at June 30, 2018. The opening and closing balances of contract assets for our Hospital Operations and other segment are as follows:

	2018	2017
January 1,	$171	$ —
June 30,	136	—
Increase/(decrease)	$(35)	$ —

The increase in the contract asset balances from the six months ended June 30, 2018 compared to the six months ended June 30, 2017 is due to the implementation of ASU 2014-09 effective January 1, 2018 using a modified retrospective method of application. Prior to January 1, 2018, amounts related to services provided to patients for which we had not billed were included in accounts receivable, less allowance for doubtful accounts, on our consolidated balance sheets. Approximately 89% of our Hospital Operations and other segment's contract assets meet the conditions for unconditional right to payment and are reclassified to patient receivables within 90 days.

Conifer Segment

Conifer enters into contracts with customers to sell revenue cycle management and other services, such as value-based care, consulting and project services. The payment terms and conditions in our customer contracts vary. In some cases, customers are invoiced in advance and (for other than fixed-price fee arrangements) a true-up to actual fee is included on a subsequent invoice. In other cases, payment is due in arrears. In addition, some contracts contain

performance incentives, penalties and other forms of variable consideration. When the timing of Conifer's delivery of services is different from the timing of payments made by the customers, Conifer recognizes either unbilled revenue (performance precedes contractual right to invoice the customer) or deferred revenue (customer payment precedes Conifer service performance). In the following table, customers that prepay prior to obtaining control/benefit of the service are represented by deferred contract revenue until the performance obligations are satisfied. Unbilled revenue represents arrangements in which Conifer has provided services to and the customer has obtained control/benefit of services prior to the contractual invoice date. Contracts with payment in arrears are recognized as receivables in the month the service is performed.

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

	Receivables	Contract Asset-Unbilled Revenue	Contract Liability-Current Deferred Revenue	Contract Liability-Long-Term Deferred Revenue
January 1, 2018	$ 89	$ 10	$ 80	$ 21
June 30, 2018	90	11	78	21
Increase/(decrease)	$ 1	$ 1	$ (2)	$ —
January 1, 2017	$ 67	$ 8	$ 76	$ 26
June 30, 2017	105	8	85	24
Increase/(decrease)	$ 38	$ —	$ 9	$ (2)

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

The amount of revenue Conifer recognized in the six months ended June 30, 2018 and 2017 that was included in the opening current deferred revenue liability was $66 million and $62 million, respectively. This revenue consists primarily of prepayments for those customers who are billed in advance, changes in estimates related to metric-based services, and up-front integration services that are recognized over the services period.

Contract Costs

We have elected to apply the practical expedient provided by FASB ASC 340-40-25-4 and expense as incurred the incremental customer contract acquisition costs for contracts in which the amortization period of the asset that we otherwise would have recognized is one year or less. However, incremental costs incurred to obtain and fulfill customer contracts for which the amortization period of the asset that we otherwise would have recognized is longer than one year, which consist primarily of Conifer deferred contract setup costs, are capitalized and amortized on a straight-line basis over the lesser of their estimated useful lives or the term of the related contract. During the three months ended June 30, 2018 and 2017, we recognized amortization expense of $3 million and $2 million, respectively. During the six months ended June 30, 2018 and 2017, we recognized amortization expense of $6 million and $4 million, respectively. At June 30, 2018 and December 31, 2017, the unamortized customer contract costs were $32 million and $35 million, respectively, and are presented as part of investments and other assets in the accompanying Condensed Consolidated Balance Sheets.

NOTE 4. ASSETS AND LIABILITIES HELD FOR SALE

In the three months ended December 31, 2017, three of our hospitals in the Chicago-area, as well as other operations affiliated with the hospitals, met the criteria to be classified as held for sale. As a result, we classified these assets totaling $113 million as "assets held for sale" in current assets and the related liabilities of $53 million as "liabilities held for sale" in current liabilities on the accompanying Condensed Consolidated Balance Sheet at June 30, 2018. These assets and liabilities, which are in our Hospital Operations and other segment, were recorded at the lower of their

carrying amount or their fair value less estimated costs to sell. We recorded impairment charges of $17 million and $73 million in the three months ended March 31, 2018 and December 31, 2017, respectively, for the write-down of the assets held for sale to their estimated fair value, less estimated costs to sell, as a result of the planned divestiture of these assets. On July 18, 2018, we announced the signing of a definitive agreement for the sale of these hospitals and hospital-affiliated operations.

In addition, certain assets and the related liabilities of our health plan in California were classified as held for sale in the three months ended December 31, 2017. We classified $13 million of assets as “assets held for sale” in current assets and the related liabilities of $21 million as “liabilities held for sale” in current liabilities on the accompanying Consolidated Balance Sheet at June 30, 2018 related to this health plan. These assets and liabilities, which are in our Hospital Operations and other segment, were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. There was no impairment recorded for a write-down of assets held for sale to their estimated fair value, less estimated costs to sell, as a result of the planned divestiture of this health plan.

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In the three months ended September 30, 2017, our nine Aspen facilities in the United Kingdom met the criteria to be classified as held for sale. We classified $326 million of our United Kingdom assets as “assets held for sale” in current assets and the related liabilities of $319 million as “liabilities held for sale” in current liabilities on the accompanying Condensed Consolidated Balance Sheet at June 30, 2018. These assets and liabilities, which are in our Ambulatory Care segment, were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. We recorded impairment charges related to this planned divestiture in the three months ended June 30, 2018 and September 30, 2017 of $4 million and $59 million, respectively, for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell.

Assets and liabilities classified as held for sale at June 30, 2018 were comprised of the following:

Accounts receivable	$ 71
Other current assets	50
Investments and other long-term assets	2
Property and equipment	322
Goodwill	7
Current liabilities	(103)
Long-term liabilities	(290)
Net assets held for sale	$ 59

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

In the three months ended March 31, 2018, we completed the sale of MacNeal Hospital, which is located in a suburb of Chicago, and other operations affiliated with the hospital; these assets met the criteria to be classified as held for sale in the three months ended September 30, 2017. As a result of this transaction, we recorded a gain on sale of $95 million and received net pre-tax cash proceeds of $249 million in the six months ended June 30, 2018.

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

In the three months ended September 30, 2017, we entered into a definitive agreement for the sale of our hospitals, physician practices and related assets in Philadelphia, Pennsylvania and the surrounding area. At that time, we recorded impairment charges of $235 million for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell, as a result of this anticipated transaction. This transaction closed in January 2018, resulting in net pre-tax proceeds of $152.5 million in cash and a secured promissory note for $17.5 million in the six months ended June 30, 2018.

The following table provides information on significant components of our business that have been disposed of since June 30, 2017 or are classified as held for sale at June 30, 2018:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017

Significant disposals:				
Income (loss) from continuing operations, before income taxes				
Houston	$—	$13	$—	$28
Philadelphia	(2)	2	(11)	(12)
MacNeal (includes a $95 million gain on sale in the 2018 period)	(4)	15	97	18
Total	$(6)	$30	$86	$34
Significant planned divestitures classified as held for sale:				
Income (loss) from continuing operations, before income taxes				
Chicago-area (includes $17 million of impairment charges in the 2018 period)	$1	$1	$(15)	$(3)
Aspen	(3)	(4)	—	(6)
Total	$(2)	$(3)	$(15)	$(9)

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

During the six months ended June 30, 2018, we recorded impairment and restructuring charges and acquisition-related costs of $77 million, consisting of $23 million of impairment charges, $47 million of restructuring charges and $7 million of acquisition-related costs. Impairment charges consisted primarily of $17 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities, $4 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $2 million of other impairment charges. Restructuring charges consisted of $26 million of employee severance costs, $5 million of contract and lease termination fees, and $16 million of other restructuring costs. Acquisition-related costs consisted of $5 million of transaction costs and $2 million of acquisition integration charges. Our impairment and restructuring charges and acquisition-related costs for the six months ended June 30, 2018 were comprised of $58 million from our Hospital Operations and other segment, $7 million from our Ambulatory Care segment and $12 million from our Conifer segment.

During the six months ended June 30, 2017, we recorded impairment and restructuring charges and acquisition-related costs of $74 million primarily related to our Hospital Operations and other segment, consisting of $17 million of impairment charges, $44 million of restructuring charges and $13 million of acquisition-related costs. Impairment charges consisted primarily of an approximately $15 million impairment of two equity method investments and $2 million to write-down intangible assets. Restructuring charges consisted of $30 million of employee severance costs, $7 million of contract and lease termination fees, and $7 million of other restructuring costs. Acquisition-related costs consisted of $2 million of transaction costs and $11 million of acquisition integration charges.

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 June 30, 2018, our continuing operations consisted of three reportable segments, Hospital Operations and other, Ambulatory Care and Conifer. Our segments are reporting units used to perform our goodwill impairment analysis.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our consolidated statements 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.

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NOTE 6. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt at June 30, 2018 and December 31, 2017:

	June 30, 2018	December 31, 2017
Senior unsecured notes:		
5.500% due 2019	$500	$ 500
6.750% due 2020	300	300
8.125% due 2022	2,800	2,800
6.750% due 2023	1,872	1,900
7.000% due 2025	478	500
6.875% due 2031	400	430
Senior secured first lien notes:		
4.750% due 2020	500	500
6.000% due 2020	1,800	1,800
4.500% due 2021	850	850
4.375% due 2021	1,050	1,050
4.625% due 2024	1,870	1,870
Senior secured second lien notes:		
7.500% due 2022	750	750
5.125% due 2025	1,410	1,410
Capital leases	417	431
Mortgage notes	78	77
Unamortized issue costs, note discounts and premiums	(208)	(231)
Total long-term debt	14,867	14,937
Less current portion	663	146
Long-term debt, net of current portion	$14,204	$ 14,791

Senior Secured and Senior Unsecured Notes

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

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

Credit Agreement

We have a senior secured revolving credit facility (as amended, the “Credit Agreement”) that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of December 4, 2020, are guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and are

secured by a first-priority lien on the accounts receivable owned by us and the subsidiary guarantors. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 0.25% to 0.75% per annum or the London Interbank Offered Rate 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 June 30, 2018, 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 Credit Agreement at June 30, 2018.

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Letter of Credit Facility

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

Drawings under any letter of credit issued under the LC Facility that we have not reimbursed within three business days after notice thereof will 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 will accrue 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 June 30, 2018, we had approximately $96 million of standby letters of credit outstanding under the LC Facility.

NOTE 7. GUARANTEES

At June 30, 2018, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $179 million. We had a total liability of $136 million recorded for these guarantees included in other current liabilities at June 30, 2018.

At June 30, 2018, we also had issued guarantees of the indebtedness and other obligations of our investees to third parties, the maximum potential amount of future payments under which was approximately $25 million. Of the total, $18 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Condensed Consolidated Balance Sheet at June 30, 2018.

NOTE 8. EMPLOYEE BENEFIT PLANS

In recent years, we have granted both options and restricted stock units to certain of our employees. 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. Typically, options and time-based restricted stock units vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have different vesting terms. In addition, we grant performance-based options and performance-based restricted stock units that vest subject to the achievement of specified performance goals within a specified time frame. At June 30, 2018, assuming outstanding performance-based restricted stock units and options for which performance has not yet been determined will achieve target performance, approximately 5.2 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other equity incentive awards, including restricted stock units (approximately 4.0 million shares remain available if we assume maximum performance for outstanding performance-based restricted stock units and options for which performance has not yet been determined).

Our Condensed Consolidated Statements of Operations for the six months ended June 30, 2018 and 2017 include $20 million and $29 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements.

Stock Options

The following table summarizes stock option activity during the six months ended June 30, 2018:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value	Weighted Average Remaining Life
			(In Millions)	
Outstanding at December 31, 2017	2,564,822	$ 20.35		
Granted	635,196	21.33		
Exercised	(581,120)	18.69		
Forfeited/Expired	(299,581)	36.21		
Outstanding at June 30, 2018	2,319,317	$ 18.99	$ 34	7.2 years
Vested and expected to vest at June 30, 2018	2,319,317	$ 18.99	$ 34	7.2 years
Exercisable at June 30, 2018	397,240	$ 17.88	$ 6	2.9 years

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There were 581,120 and 11,175 stock options exercised during the six months ended June 30, 2018 and 2017, respectively, with aggregate intrinsic values of approximately $3 million and less than $1 million, respectively.

At June 30, 2018, there were $8 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 2.2 years.

In the three months ended June 30, 2018, we granted new senior officers 31,184 performance-based stock options. The options will all vest on the third anniversary of the grant date, subject to achieving a closing stock price of at least $44.29 (a 25% premium above the May 31, 2018 grant-date closing stock price of $35.43) for at least 20 consecutive trading days within three years of the grant date, and will expire on the tenth anniversary of the grant date.

In the three months ended March 31, 2018, we granted an aggregate of 604,012 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. The stock options will all vest on the third anniversary of the grant date because, in the three months ended June 30, 2018, the requirement that our stock close at a price of at least $25.75 (a 25% premium above the February 28, 2018 grant-date closing stock price of $20.60) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date. In the three months ended March 31, 2017, we granted an aggregate of 987,781 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. The stock options will all vest on the third anniversary of the grant date because, in the three months ended June 30, 2018, the requirement that our stock close at a price of at least $23.74 (a 25% premium above the March 1, 2017 grant-date closing stock price of $18.99) for at least 20 consecutive trading days within three years of the grant date was met; these options will expire on the tenth anniversary of the grant date.

The weighted average estimated fair value of stock options we granted in the six months ended June 30, 2018 and 2017 was $9.16 and $8.52 per share, respectively. These fair values were calculated based on each grant date, using a Monte Carlo simulation with the following assumptions:

	Six Months Ended June 30,	
	2018	2017
Expected volatility	46%	49%
Expected dividend yield	0%	0%
Expected life	6.2 years	6.2 years
Expected forfeiture rate	0%	0%
Risk-free interest rate	2.72%	2.15%

The expected volatility used in 2018 for the Monte Carlo simulation incorporates historical volatility based on an analysis of historical prices of our stock. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options; it does not consider the implied volatility from open-market exchanged options due to the limited trading activity and the transient nature of factors impacting our stock price volatility. The expected volatility used in 2017 for the Monte Carlo simulation incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflected the historical volatility for a duration consistent with the contractual life of the options, as well as the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility for 2018 excludes the movements in our stock price for the period from August 15, 2017 through November 30, 2017 due to the departure of certain board members and officers, as well as reports that we were exploring a potential sale of the company. The historical share-price volatility for 2017 excludes the movements in our stock price on two dates (April 8, 2011 and April 11, 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from Tenet’s historical stock option

exercise behavior, adjusted for the exercisable period (i.e., from the third anniversary through the tenth anniversary of the grant date). The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise time frames.

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The following table summarizes information about our outstanding stock options at June 30, 2018:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	105,934	0.7 years	$ 4.56	105,934	$ 4.56
$4.57 to $19.759	1,292,315	7.2 years	18.18	5,434	18.99
$19.76 to $35.430	921,068	7.8 years	21.78	285,872	22.79
	2,319,317	7.2 years	$ 18.99	397,240	$ 17.88

Restricted Stock Units

The following table summarizes restricted stock unit activity during the six months ended June 30, 2018:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2017	2,253,988	$ 35.20
Granted	730,577	24.68
Vested	(812,166)	34.76
Forfeited	(96,597)	41.77
Unvested at June 30, 2018	2,075,802	$ 31.37

In the six months ended June 30, 2018, we granted 730,577 restricted stock units, of which 288,325 will vest and be settled ratably over a three-year period from the grant date, 339,806 will vest and be settled ratably over a two-year period from the grant date, and 26,356 will vest and be settled on the third anniversary of the grant date. In addition, in May 2018, we made an annual grant of 54,198 restricted stock units to our non-employee directors for the 2018-2019 board service year, which units vested immediately and will settle in shares of our common stock on the third anniversary of the date of the grant. Because the board of directors appointed two new members in May 2018, we made initial grants totaling 3,670 restricted stock units to these directors, as well as prorated annual grants totaling 12,154 restricted stock units. Both the initial grants and the annual grants vested immediately, however the initial grants will not settle until the directors' separation from the Board, while the annual grants settle on the third anniversary of the grant date. In addition, we granted 6,068 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of specified performance goals for the years 2018 to 2020. Provided the goals are achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 6,068 units granted, depending on our level of achievement with respect to the performance goals.

At June 30, 2018, there were $27 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 1.8 years.

Employee Retirement Plans

In the six-month periods ended June 30, 2018 and 2017, we recognized (i) service cost related to one of our frozen nonqualified defined benefit pension plans of approximately $1 million in salaries, wages and benefits expense for both periods, and (ii) other components of net periodic pension cost and net periodic postretirement benefit cost related to our frozen qualified and nonqualified defined benefit plans of approximately $8 million and $14 million, respectively, in other non-operating expense, net, in the accompanying Condensed Consolidated Statements of Operations.

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NOTE 9. EQUITY

Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the six months ended June 30, 2018 and 2017 (dollars in millions, share amounts in thousands):

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock							
	Shares Outstanding	Issued Par Amount	Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balances at December 31, 2017	100,972	$ 7	$ 4,859	$ (204)	$ (2,390)	$ (2,419)	$ 686	$ 539
Net income	—	—	—	—	125	—	73	198
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(72)	(72)
Other comprehensive income	—	—	—	4	—	—	—	4
Accretion of redeemable noncontrolling interests	—	—	(160)	—	—	—	—	(160)
Purchases (sales) of businesses and noncontrolling interests	—	—	(6)	—	—	—	43	37
Cumulative effect of accounting change	—	—	—	(43)	43	—	—	—
Stock-based compensation expense, tax benefit and issuance of common stock	1,329	—	29	—	—	1	—	30
Balances at June 30, 2018	102,301	$ 7	$ 4,722	$ (243)	$ (2,222)	$ (2,418)	$ 730	$ 576
Balances at December 31, 2016	99,686	$ 7	$ 4,827	$ (258)	$ (1,742)	$ (2,417)	$ 665	$ 1,082
Net income (loss)	—	—	—	—	(108)	—	71	(37)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(65)	(65)
Other comprehensive income	—	—	—	16	—	—	—	16
Accretion of redeemable noncontrolling interests	—	—	(29)	—	—	—	—	(29)
Purchases (sales) of businesses and noncontrolling interests	—	—	(4)	—	—	—	11	7
Cumulative effect of accounting change	—	—	—	—	56	—	—	56
Stock-based compensation expense and issuance of common stock	1,024	—	25	—	—	—	—	25
Balances at June 30, 2017	100,710	$ 7	$ 4,819	$ (242)	$ (1,794)	$ (2,417)	$ 682	$ 1,055

Our noncontrolling interests balances at June 30, 2018 and December 31, 2017 were comprised of $65 million and $64 million, respectively, from our Hospital Operations and other segment, and $665 million and $622 million, respectively, from our Ambulatory Care segment. Our net income available to noncontrolling interests for the six months ended June 30, 2018 and 2017 in the table above were comprised of $4 million and $9 million, respectively, from our Hospital Operations and other segment, and $69 million and $62 million, respectively, from our Ambulatory Care segment.

NOTE 10. NET OPERATING REVENUES

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Hospital Operations and other:				
Net patient service revenues less provision for doubtful accounts from hospitals and related outpatient facilities				
Medicare	$701	$820	$1,483	$1,682
Medicaid	314	279	635	554
Managed care	2,273	2,451	4,641	4,884
Self-pay	8	18	45	31
Indemnity and other	147	151	282	296
Total	3,443	3,719	7,086	7,447
Physician practices revenues less provision for doubtful accounts	270	271	545	540
Health plans	—	25	6	90
Revenue from other sources	20	70	43	123
Hospital Operations and other total prior to inter-segment eliminations	3,733	4,085	7,680	8,200
Ambulatory Care	531	472	1,029	927
Conifer	386	400	790	802
Inter-segment eliminations	(144)	(155)	(294)	(314)
Net operating revenues	$4,506	$4,802	$9,205	$9,615

Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the six month periods ended June 30, 2018 and 2017 by $11 million and $29 million, respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Condensed Consolidated Balance Sheets (see Note 2). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Net patient service revenues less provision for doubtful accounts	$500	$443	$969	$871
Management fees	23	23	46	44
Revenue from other sources	8	6	14	12
Net operating revenues	$531	$472	$1,029	$927

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Revenue cycle services – Tenet	$139	$145	$283	$292
Revenue cycle services – other customers	220	221	452	445

Other services – Tenet	5	10	11	22
Other services – other customers	22	24	44	43
Net operating revenues	$386	$400	$790	$802

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

Performance Obligations

The following table includes Conifer's revenue that is expected to be recognized in the future related to performance obligations that are unsatisfied, or partially unsatisfied, at the end of the reporting period. The amounts in the table primarily consist of revenue cycle management fixed fees, which are typically recognized ratably as the performance obligation is satisfied. The estimated revenue does not include volume or contingency based contracts, performance incentives, penalties or

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other variable consideration that is considered constrained. Conifer's contract with Catholic Health Initiatives ("CHI"), a minority interest owner of Conifer Health Solutions, LLC, represents the majority of the fixed fee revenue related to remaining performance obligations. Conifer's contract term with CHI ends in 2032.

	Total	Six Months Ending December 31, 2018	Years Ending 2019	2020	2021	2022	Later Years
Performance obligations	$8,216	$327	$658	$652	$604	$576	$5,399

NOTE 11. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy period April 1, 2018 through March 31, 2019, we have coverage totaling $850 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million for floods, $200 million for earthquakes and a per-occurrence sub-limit of $200 million for named windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and named windstorms, the total $850 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for California earthquakes, floods and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Floods and certain other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Reserves

At June 30, 2018 and December 31, 2017, the aggregate current and long-term professional and general liability reserves in our accompanying Condensed Consolidated Balance Sheets were approximately $860 million and $854 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.81% at June 30, 2018 and 2.33% at December 31, 2017.

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

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $163 million and $167 million for the six months ended June 30, 2018 and 2017, respectively.

NOTE 12. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. We and our subsidiaries have received inquiries in recent years from government agencies, and we may receive similar inquiries in future periods. We are also subject to class action

lawsuits, employment-related claims and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us.

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

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. Significant judgment is required in both the determination of the probability of a loss and the determination as to whether a loss is reasonably estimable. These determinations are updated at least quarterly and are adjusted to reflect the effects of negotiations, settlements, rulings, advice of legal counsel and technical experts, and other information and events pertaining to a particular matter. If a loss on a material

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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.

Shareholder Derivative Litigation

In January 2017, the Dallas County District Court consolidated two previously disclosed shareholder derivative lawsuits filed by purported shareholders of the Company's common stock on behalf of the Company against current and former officers and directors into a single matter captioned In re Tenet Healthcare Corporation Shareholder Derivative Litigation. The plaintiffs filed a consolidated shareholder derivative petition in February 2017. (A separate shareholder derivative lawsuit, captioned Horwitz, derivatively on behalf of Tenet Healthcare Corporation, was filed in January 2017 in the U.S. District Court for the Northern District of Texas; however, on January 19, 2018, the plaintiff in the Horwitz matter voluntarily dismissed his case.) The consolidated shareholder derivative petition alleges that false or misleading statements or omissions concerning the Company's financial performance and compliance policies, specifically with respect to the previously disclosed civil qui tam litigation and parallel criminal investigation of the Company and certain of its subsidiaries (together, the "Clinica de la Mama matters"), caused the price of the Company's common stock to be artificially inflated. In addition, the plaintiffs allege that the defendants violated GAAP by failing to disclose an estimate of the possible loss or a range of loss related to the Clinica de la Mama matters. The plaintiffs claim that they did not make demand on the Company's board of directors to bring the lawsuit because such a demand would have been futile. In May 2017, the judge in the consolidated shareholder derivative litigation entered an order staying that matter pending the final resolution of the previously disclosed consolidated securities litigation that was ultimately dismissed in December 2017. On May 23, 2018, the judge entered an order lifting the stay and, on July 6, 2018, the defendants filed pleadings seeking dismissal of the lawsuit. The defendants intend to vigorously defend against the allegations in the remaining purported shareholder derivative lawsuit.

Antitrust Class Action Lawsuit Filed by Registered Nurses in San Antonio

In Maderazo, et al. v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al., filed in June 2006 in the U.S. District Court for the Western District of Texas, a purported class of registered nurses employed by three unaffiliated San Antonio-area hospital systems allege those hospital systems, including our Baptist Health System, and other unidentified San Antonio regional hospitals violated Section §1 of the federal Sherman Act by conspiring to depress nurses' compensation and exchanging compensation-related information among themselves in a manner that reduced competition and suppressed the wages paid to such nurses. The suit seeks unspecified damages (subject to trebling under federal law), interest, costs and attorneys' fees. The case was stayed from 2008 through mid-2015. At this time, we are awaiting the court's ruling on class certification and will continue to 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.

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The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the six months ended June 30, 2018 and 2017:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Balances at End of Period
Six Months Ended June 30, 2018				
Continuing operations	$ 12	$ 19	$ (11)	$ 20
Discontinued operations	—	—	—	—
	$ 12	$ 19	$ (11)	$ 20
Six Months Ended June 30, 2017				
Continuing operations	$ 12	$ 6	$ (13)	$ 5
Discontinued operations	—	—	—	—
	$ 12	$ 6	$ (13)	$ 5

For the six months ended June 30, 2018 and 2017, we recorded costs of $19 million and $6 million, respectively, in continuing operations in connection with significant legal proceedings and governmental investigations.

NOTE 13. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

As previously disclosed, as part of the acquisition of United Surgical Partners International in 2015, we entered into a put/call agreement (the “Put/Call Agreement”) with respect to the equity interests in USPI held by our joint venture partners. In January 2016, Welsh, Carson, Anderson & Stowe (“WCAS”), 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 those shares, which increased our ownership interest in USPI to approximately 56.3%. On May 1, 2017, we amended and restated the Put/Call Agreement to provide for, among other things, the acceleration of our acquisition of certain shares of USPI. On July 3, 2017, we paid approximately $716 million for the purchase of 23.7% of USPI, which increased our ownership interest to 80.0%, as well as the final adjustment to the 2016 purchase price. In April 2018, we reached an agreement with WCAS on behalf of our joint venture partners to provide for the acceleration of our acquisition of all the remaining shares they owned in USPI and the settlement of adjustments to the price we paid for the shares we purchased from our joint venture partners in 2017. Under the terms of the agreement, we paid WCAS approximately $630 million to buy our joint venture partners’ 15% ownership interest in USPI and to settle the adjustment to the price we paid in 2017 based on actual 2017 financial results. The agreement also satisfied any obligations under the previous amended and restated Put/Call Agreement with WCAS, including any future adjustments to the price for any future financial results of USPI. At June 30, 2018, we owned 95.0% of USPI, as the agreement with WCAS did not have any impact on the separate put/call agreement with Baylor University Medical Center for the 5% ownership interest it holds in USPI. Due to the accelerations of our acquisitions of shares of USPI, we recorded the differences between the carrying values and the purchase prices as accretion of redeemable noncontrolling interest and additional paid-in-capital in the six months ended June 30, 2018 and 2017.

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the six months ended June 30, 2018 and 2017:

	Six Months Ended June 30,	
	2018	2017
Balances at beginning of period	$1,866	$2,393

Net income	101	105
Distributions paid to noncontrolling interests	(70)	(58)
Accretion of redeemable noncontrolling interests	160	29
Purchases and sales of businesses and noncontrolling interests, net	(628)	(688)
Balances at end of period	$1,429	$1,781

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The following tables show the composition by segment of our redeemable noncontrolling interests balances at June 30, 2018 and December 31, 2017, as well as our net income available to redeemable noncontrolling interests for the six months ended June 30, 2018 and 2017:

	June 30, 2018	December 31, 2017
Hospital Operations and other	$ 503	$ 519
Ambulatory Care	678	1,137
Conifer	248	210
Redeemable noncontrolling interests	$ 1,429	$ 1,866

	Six Months Ended June 30,	
	2018	2017
Hospital Operations and other	$(6)	$12
Ambulatory Care	70	70
Conifer	37	23
Net income available to redeemable noncontrolling interests	$101	$105

NOTE 14. INCOME TAXES

During the three months ended June 30, 2018, we recorded income tax expense of $44 million in continuing operations on pre-tax income of $150 million compared to an income tax benefit of $12 million on pre-tax income of $19 million during the three months ended June 30, 2017. During the six months ended June 30, 2018, we recorded income tax expense of $114 million in continuing operations on pre-tax income of $410 million compared to an income tax benefit of $45 million on pre-tax income of $23 million during the six months ended June 30, 2017. Our provision for income taxes during interim reporting periods is calculated by applying an estimate of the annual effective tax rate for the full year to “ordinary” income or loss (pre-tax income or loss excluding unusual or infrequently occurring discrete items) for the reporting period. In calculating “ordinary” income, non-taxable income or loss attributable to non-controlling interests has been deducted from pre-tax income or loss in the determination of the annualized effective tax rate used to calculate income taxes for the quarter. The reconciliation between the amount of recorded income tax expense (benefit) and the amount calculated at the statutory federal tax rate is shown in the following table:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Tax expense at statutory federal rate of 21% (35% for 2017)	$31	$7	$86	$8
State income taxes, net of federal income tax benefit	7	12	17	5
Tax benefit available to noncontrolling interests	(16)	(28)	(34)	(54)
Nondeductible goodwill	2	—	7	—
Change in tax contingency reserves, including interest	—	—	—	(2)
Stock-based compensation	—	1	4	9
Change in valuation allowance-interest expense limitation	18	—	30	—
Other items	2	(4)	4	(11)
Income tax expense (benefit)	$44	$(12)	$114	$(45)

During the six months ended June 30, 2018, there were no adjustments to our estimated liabilities for uncertain tax positions. The total amount of unrecognized tax benefits at June 30, 2018 was $46 million, of which $44 million, if

recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. Total accrued interest and penalties on unrecognized tax benefits at June 30, 2018 were $3 million, all of which related to continuing operations.

At June 30, 2018, approximately $1 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.

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NOTE 15. EARNINGS (LOSS) PER COMMON SHARE

The following table is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for our continuing operations for three and six months ended June 30, 2018 and 2017. Net income available (loss attributable) to our common shareholders is expressed in millions and weighted average shares are expressed in thousands.

	Net Income Available (Loss Attributable) to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended June 30, 2018			
Net income available to Tenet Healthcare Corporation common shareholders for basic loss per share	$ 24	102,147	$ 0.23
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,030	—
Net income available to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ 24	104,177	$ 0.23
Three Months Ended June 30, 2017			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (56)	100,612	$ (0.56)
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	$ (56)	100,612	$ (0.56)
Six Months Ended June 30, 2018			
Net income available to Tenet Healthcare Corporation common shareholders for basic loss per share	$ 122	101,770	$ 1.20
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	1,646	(0.02)
Net income available to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ 122	103,416	$ 1.18
Six Months Ended June 30, 2017			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (108)	100,306	$ (1.08)
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	$ (108)	100,306	$ (1.08)

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three and six months ended June 30, 2017 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 three and six months ended June 30, 2017, 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 682 and 766 for the three and six months ended June 30, 2017, respectively.

NOTE 16. FAIR VALUE MEASUREMENTS

Our non-financial assets and liabilities not permitted or required to be measured at fair value on a recurring basis typically relate to long-lived assets held and used, long-lived assets held for sale and goodwill. We are required to provide additional disclosures about fair value measurements as part of our financial statements for each major category of assets and liabilities measured at fair value on a non-recurring basis. The following tables present this information and indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by

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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.

	June 30, 2018	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held for sale	$ 322	$ —	$ 322	$ —
	$ 322	$ —	$ 322	$ —

	December 31, 2017	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held for sale	$ 456	$ —	$ 456	$ —
Other than temporarily impaired equity method investments	113	—	113	—
	$ 569	$ —	$ 569	$ —

As described in Note 5, in the six months ended June 30, 2018, we recorded $23 million of impairment charges, consisting primarily of $17 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for certain of our Chicago-area facilities, $4 million of charges to write-down assets held for sale to their estimated fair value, less estimated costs to sell, for Aspen and $2 million of other impairment charges.

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 June 30, 2018 and December 31, 2017, the estimated fair value of our long-term debt was approximately 100.0% and 100.2%, respectively, of the carrying value of the debt.

NOTE 17. ACQUISITIONS

Preliminary purchase price allocations (representing the fair value of the consideration conveyed) for all acquisitions made during the six months ended June 30, 2018 and 2017 are as follows:

	Six Months Ended June 30,	
	2018	2017
Current assets	$3	$ 3

Property and equipment	3	4
Other intangible assets	3	5
Goodwill	132	43
Other long-term assets	1	—
Current liabilities	(2)	(2)
Long-term liabilities	(1)	(1)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(8)	(10)
Noncontrolling interests	(42)	(13)
Cash paid, net of cash acquired	(89)	(26)
Gains on consolidations	$—	$ 3

The goodwill generated from these transactions, the majority of which will be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. The goodwill total of $132 million from acquisitions completed during the six months ended June 30, 2018 was recorded in our Ambulatory Care segment. Approximately $5 million and $2 million in transaction costs related to prospective and closed acquisitions were expensed during the six month periods ended June 30, 2018 and 2017, respectively, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statements of Operations.

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We are required to allocate the purchase prices of acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, other intangible assets and noncontrolling interests for some of our 2018 and 2017 acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed.

During the six months ended June 30, 2018 and 2017, we recognized gains totaling less than $1 million and $3 million, respectively, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

NOTE 18. SEGMENT INFORMATION

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

Our Hospital Operations and other segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. At June 30, 2018, our subsidiaries operated 68 hospitals (certain of which are classified as held for sale, as described in Note 4), serving primarily urban and suburban communities in 10 states.

Our Ambulatory Care segment is comprised of the operations of USPI and our nine Aspen facilities in the United Kingdom, which are classified as held for sale in the accompanying Condensed Consolidated Balance Sheets at June 30, 2018 and December 31, 2017. At June 30, 2018, USPI had interests in 254 ambulatory surgery centers, 35 urgent care centers, 23 imaging centers and 21 surgical hospitals in 27 states. At June 30, 2018, we owned 95.0% of USPI.

Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities. At June 30, 2018, Conifer provided services to approximately 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. At June 30, 2018, we owned 76.2% of Conifer Health Solutions, LLC, which is the principal subsidiary of Conifer Holdings, Inc.

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

	June 30, 2018	December 31, 2017
Assets:		
Hospital Operations and other	$ 15,396	$ 16,466
Ambulatory Care	5,865	5,822
Conifer	1,082	1,097
Total	$ 22,343	$ 23,385

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	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Capital expenditures:				
Hospital Operations and other	$108	$136	$228	$319
Ambulatory Care	13	10	28	21
Conifer	4	4	12	8
Total	$125	$150	$268	$348
Net operating revenues:				
Hospital Operations and other total prior to inter-segment eliminations(1)	$3,733	$4,085	$7,680	$8,200
Ambulatory Care	531	472	1,029	927
Conifer				
Tenet	144	155	294	314
Other customers	242	245	496	488
Total Conifer	386	400	790	802
Inter-segment eliminations	(144)	(155)	(294)	(314)
Total	$4,506	$4,802	$9,205	$9,615
Equity in earnings of unconsolidated affiliates:				
Hospital Operations and other	$6	$(2)	$4	$—
Ambulatory Care	33	30	60	57
Total	$39	$28	$64	$57
Adjusted EBITDA(2):				
Hospital Operations and other(2)	$345	$346	$747	$655
Ambulatory Care	198	164	363	317
Conifer	91	60	189	125
Total	$634	$570	$1,299	$1,097
Depreciation and amortization:				
Hospital Operations and other	$164	$188	$339	$375
Ambulatory Care	17	22	34	44
Conifer	13	12	25	24
Total	$194	$222	$398	$443

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Adjusted EBITDA(2)	$634	$570	$1,299	$1,097
Income (loss) from divested and closed businesses (i.e., the Company's health plan businesses)	1	(19)	—	(35)
Depreciation and amortization	(194)	(222)	(398)	(443)
Impairment and restructuring charges, and acquisition-related costs	(30)	(41)	(77)	(74)
Litigation and investigation costs	(13)	(1)	(19)	(6)
Interest expense	(254)	(260)	(509)	(518)

Loss from early extinguishment of debt	(1)	(26)	(2)	(26)
Other non-operating expense, net	(1)	(5)	(2)	(10)
Net gains on sales, consolidation and deconsolidation of facilities	8	23	118	38
Income from continuing operations, before income taxes	$150	$19	$410	$23

(1) Hospital Operations and other revenues includes health plan revenues of less than $1 million and $6 million for the three and six months ended June 30, 2018, respectively, and $25 million and $90 million for the three and six months ended June 30, 2017, respectively.

(2) Hospital Operations and other Adjusted EBITDA excludes health plan EBITDA of $1 million and less than $1 million for the three and six months ended June 30, 2018, respectively, and $(19) million and $(35) million for the three and six months ended June 30, 2017, respectively.

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NOTE 19. RECENT ACCOUNTING STANDARDS

In February 2016, the FASB issued ASU 2016-02, “Leases (Topic 842)” (“ASU 2016-02”), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and current GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under current GAAP. Recognition of these assets and liabilities will have a material impact to our consolidated balance sheets upon adoption. Under ASU 2016-02, lessees and lessors are required to recognize and measure leases at the beginning of the earliest period presented using a modified retrospective approach, which includes a number of optional practical expedients. In July 2018, the FASB issued ASU 2018-11 “Leases (Topic 842) Targeted Improvements,” which allows lessees and lessors to recognize and measure leases at the beginning of the period of adoption without modifying the comparative period financial statements. This guidance will be effective for us beginning in 2019, and we intend to use the retrospective method as of the period of adoption rather than the earliest period presented. We are currently in the process of executing our implementation plan by installing a lease accounting technology system, gathering lease contracts and abstracting key financial data, and finalizing design of revisions needed to our processes and internal controls. We are also continuing to evaluate accounting policy options under the standard, including the use of the optional practical expedients, and evaluating the impact of implementing this guidance on our consolidated financial statements.

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ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our Hospital Operations and other segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 4 to the accompanying Condensed Consolidated Financial Statements, certain of our facilities were classified as held for sale at June 30, 2018. Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI"), in which we own a majority interest, and European Surgical Partners Limited ("Aspen") facilities, which were classified as held for sale at June 30, 2018. At June 30, 2018, USPI had interests in 254 ambulatory surgery centers, 35 urgent care centers, 23 imaging centers and 21 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 Condensed Consolidated Financial Statements, includes the following sections:

- Management Overview
- Forward-Looking Statements
- Sources of Revenue for Our Hospital Operations and Other Segment
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per adjusted admission, per adjusted patient day and per case amounts). Continuing operations information includes the results of (i) our same 68 hospitals operated throughout the six months ended June 30, 2018 and 2017, (ii) three Houston-area hospitals, which we divested effective August 1, 2017, (iii) Abrazo Maryvale Campus, which we closed in December 2017, (iv) two Philadelphia-area hospitals, which we divested effective January 11, 2018, (v) MacNeal Hospital, which we divested effective March 1, 2018, and (vi) Des Peres Hospital, which we divested effective May 1, 2018. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. In addition, although we operated four North Texas hospitals throughout the six months ended June 30, 2017 and from January 1 through February 28, 2018, we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Definitive Agreement to Sell Remaining Hospitals in Chicago Area—On July 18, 2018, we announced the signing of a definitive agreement for the sale of our three hospitals and hospital-affiliated operations in the Chicago area. This sale, which is subject to customary closing conditions, including regulatory approvals, is expected to be completed in the fourth quarter of 2018. For additional details, see Note 4 to the accompanying Condensed Consolidated Financial Statements.

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TRENDS AND STRATEGIES

The healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on legislative and administrative 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”). Although it is difficult to predict the full impact of this regulatory uncertainty on our future revenues and operations, we believe that our strategies will help us to address the following trends shaping the demand for healthcare services: (1) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (2) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (3) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (4) consolidation continues across the entire healthcare sector.

Driving Growth in Our Hospital Systems—We are committed to better positioning our hospital systems and competing more effectively in the ever-evolving healthcare environment. We are focused on improving operational effectiveness, increasing capital efficiency and margins, enhancing patient satisfaction, growing our higher-acuity inpatient service lines, expanding patient access points, and exiting service lines, businesses and markets that we believe are no longer strategic to our long-term growth. We have undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions and the renegotiation of contracts with suppliers and vendors, which are intended to lower annual operating expenses by $250 million. We anticipate achieving the full annualized run-rate savings by the end of 2018. Most of the savings are expected to be achieved through actions within our Hospital Operations and other segment, including the elimination of a regional management layer and streamlined corporate overhead and centralized support functions. In conjunction with these initiatives, we incurred restructuring charges related to employee severance payments of approximately $26 million in the six months ended June 30, 2018, and we expect to incur additional such restructuring charges in the remainder of 2018.

Expansion of Our Ambulatory Care Segment—We remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We believe USPI’s surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability, flexibility and convenience. Moreover, due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable at a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. In addition, we have continued to grow our imaging and urgent care businesses through USPI to reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

Exploration of a Potential Sale of Conifer While Continuing to Drive Conifer’s Growth—In late 2017, we announced additional actions to support our goals of improving financial performance and enhancing shareholder value, including the exploration of a potential sale of Conifer. During this time, we remain focused on driving growth at Conifer by continuing to market and expand its revenue cycle management and value-based care solutions businesses. Conifer serves approximately 800 Tenet and non-Tenet hospital and other clients nationwide. In addition to providing revenue cycle management services to both healthcare systems and physicians, Conifer provides support to both providers and self-insured employers seeking assistance with clinical integration, financial risk management and population health management.

Improving Profitability—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, co-insurance amounts and deductibles, changing consumer behavior, and adverse economic conditions and demographic trends in certain of our markets. However, we also believe that targeted capital spending on growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our ambulatory care business and contracting strategies that create shared value with payers should help us grow our patient volumes.

Reducing Our Leverage—All of our outstanding long-term debt has a fixed rate of interest, and the maturity dates of our notes are staggered from 2019 through 2031. Although we believe that our capital structure minimizes the near-term impact of increased interest rates, and the staggered maturities of our debt allow us to refinance our debt over time, it is nonetheless our long-term objective to lower our ratio of debt-to-Adjusted EBITDA, primarily through more efficient capital allocation and Adjusted EBITDA growth, which should lower our refinancing risk and increase the potential for us to continue to use lower rate secured debt to refinance portions of our higher rate unsecured debt.

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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 our Annual Report on Form 10-K for the year ended December 31, 2017 ("Annual Report").

RESULTS OF OPERATIONS—OVERVIEW

The following tables show certain selected operating statistics for our continuing operations, which includes the results of (i) our same 68 hospitals operated throughout the six months ended June 30, 2018 and 2017, (ii) three Houston-area hospitals, which we divested effective August 1, 2017, (iii) Abrazo Maryvale Campus, which we closed in December 2017, (iv) two Philadelphia-area hospitals, which we divested effective January 11, 2018, (v) MacNeal Hospital, which we divested effective March 1, 2018, and (vi) Des Peres Hospital, which we divested effective May 1, 2018. 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.

	Continuing Operations Three Months Ended June 30,			
Selected Operating Statistics	2018	2017	Increase (Decrease)	
Hospital Operations and other – hospitals and related outpatient facilities				
Number of hospitals (at end of period)	68	76	(8)	(1)
Total admissions	168,453	190,394	(11.5)%	
Adjusted patient admissions(2)	306,063	342,439	(10.6)%	
Paying admissions (excludes charity and uninsured)	158,216	179,889	(12.0)%	
Charity and uninsured admissions	10,237	10,505	(2.6)%	
Emergency department visits	643,036	724,785	(11.3)%	
Total surgeries	110,079	123,449	(10.8)%	
Patient days — total	766,519	874,930	(12.4)%	
Adjusted patient days(2)	1,373,480	1,552,302	(11.5)%	
Average length of stay (days)	4.55	4.60	(1.1)%	
Average licensed beds	18,362	20,435	(10.1)%	
Utilization of licensed beds(3)	45.9%	47.0%	(1.1)%	(1)
Total visits	1,749,847	1,981,848	(11.7)%	
Paying visits (excludes charity and uninsured)	1,633,372	1,849,697	(11.7)%	
Charity and uninsured visits	116,475	132,151	(11.9)%	
Ambulatory Care				
Total consolidated facilities (at end of period)	232	219	13	(1)
Total cases	500,516	462,174	8.3%	

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

(2) Adjusted patient admissions/days represents actual patient admissions/days

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

Total admissions decreased by 21,941, or 11.5%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, and total surgeries decreased by 13,370, or 10.8%, in the 2018 period compared to the 2017 period. Our emergency department visits decreased 11.3% in the three months ended June 30, 2018 compared to the same period in the prior year. Our volumes from continuing operations in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 were negatively affected by the sale of our Houston-area facilities effective August 1, 2017, the closure of our Abrazo Maryvale Campus in December 2017, the sale of our Philadelphia-area facilities effective January 11, 2018, the sale of MacNeal Hospital and affiliated operations effective March 1, 2018, and the sale of Des Peres Hospital and affiliated operations effective May 1, 2018. Our Ambulatory Care total cases increased 8.3% due to the increase in consolidated facilities.

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Revenues	Continuing Operations Three Months Ended June 30, 2018	2017	Increase (Decrease)
Net operating revenues			
Hospital Operations and other prior to inter-segment eliminations	$3,733	$4,085	(8.6)%
Ambulatory Care	531	472	12.5 %
Conifer	386	400	(3.5)%
Inter-segment eliminations	(144)	(155)	(7.1)%
Total	$4,506	$4,802	(6.2)%

Net operating revenues decreased by $296 million, or 6.2%, in the three months ended June 30, 2018 compared to the same period in 2017, primarily due to the sale and closure of facilities described above. For our Hospital Operations and other segment, the decrease in net operating revenues was partially mitigated by improved managed care pricing. Also, the 2018 period included $63 million of net revenues from the California provider fee program compared to no revenue recorded under this program in the 2017 period because the extension of the program had not yet been approved by the Centers for Medicare and Medicaid Services (“CMS”).

Our accounts receivable days outstanding (“AR Days”) from continuing operations (which calculation includes our Hospital Operations and other contract assets subsequent to the adoption of the Financial Accounting Standards Board Accounting Standards Update 2014-09, “Revenue from Contracts with Customers (Topic 606)” (“ASU 2014-09”) effective January 1, 2018 and the accounts receivable of our Chicago-area and Aspen facilities that have been classified in assets held for sale on our Condensed Consolidated Balance Sheet at June 30, 2018, and excludes (i) three Houston-area hospitals, which we divested effective August 1, 2017, (ii) Abrazo Maryvale Campus, which we closed in December 2017, (iii) two Philadelphia-area hospitals, which we divested effective January 11, 2018, (iv) MacNeal Hospital, which we divested effective March 1, 2018, (v) Des Peres Hospital, which we divested effective May 1, 2018, (vi) health plan revenues, and (vii) our California provider fee revenues) were 55.1 days at June 30, 2018 and 55.8 days at December 31, 2017, compared to our target of less than 55 days.

Selected Operating Expenses	Continuing Operations Three Months Ended June 30, 2018	2017	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$1,756	$1,943	(9.6)%
Supplies	641	682	(6.0)%
Other operating expenses	852	982	(13.2)%
Total	$3,249	$3,607	(9.9)%
Ambulatory Care			
Salaries, wages and benefits	$165	$153	7.8 %
Supplies	106	96	10.4 %
Other operating expenses	95	89	6.7 %
Total	$366	$338	8.3 %
Conifer			
Salaries, wages and benefits	$214	$250	(14.4)%
Supplies	1	2	(50.0)%
Other operating expenses	80	88	(9.1)%
Total	$295	$340	(13.2)%

Total				
Salaries, wages and benefits	$2,135	$2,346	(9.0	)%
Supplies	748	780	(4.1	)%
Other operating expenses	1,027	1,159	(11.4	)%
Total	$3,910	$4,285	(8.8	)%
Rent/lease expense(1)				
Hospital Operations and other	$56	$61	(8.2	)%
Ambulatory Care	20	19	5.3	%
Conifer	5	5	—	%
Total	$81	$85	(4.7	)%

(1) Included in other operating expenses.

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Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended June 30, 2018	2017	Increase (Decrease)	
Hospital Operations and other				
Salaries, wages and benefits per adjusted patient admission(1)	$5,736	$5,662	1.3	%
Supplies per adjusted patient admission(1)	2,092	1,995	4.9	%
Other operating expenses per adjusted patient admission(1)	2,791	2,737	2.0	%
Total per adjusted patient admission	$10,619	$10,394	2.2	%

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

inpatient
revenues.

Salaries, wages and benefits per adjusted patient admission increased 1.3% in the three months ended June 30, 2018 compared to the same period in 2017. This change is primarily due to annual merit increases for certain of our employees and increased health benefits costs, partially offset by the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives.

Supplies expense per adjusted patient admission increased 4.9% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 primarily due to increased costs from certain higher acuity supply-intensive surgical services.

Other operating expenses per adjusted patient admission increased by 2.0% in the three months ended June 30, 2018 compared to the prior-year period. This increase is primarily due to the effect of lower volumes on operating leverage due to certain fixed costs. Also, other operating expenses in the 2017 period were offset by gains on sales of assets of $23 million primarily related to the sale of home health and hospice assets. In the 2018 period, we recognized a favorable adjustment of approximately $3 million from a 13 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities. In the 2017 period, we recognized an unfavorable adjustment of approximately $2 million from an eight basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $403 million at June 30, 2018 compared to $974 million at March 31, 2018.

Significant cash flow items in the three months ended June 30, 2018 included:

- Net cash provided by operating activities before interest, taxes, discontinued operations and restructuring charges, acquisition-related costs, and litigation costs and settlements of $734 million;
- A payment of $630 million to Welsh, Carson, Anderson & Stowe to increase our ownership interest in USPI from 80% to 95%;
- Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements of $30 million;
- Capital expenditures of $125 million;
- $73 million of payments for the purchases of businesses or joint venture interests;
- Proceeds from the sales of facilities and other assets of $56 million;
- Interest payments of $332 million;
- $28 million of payments to purchase approximately $30 million aggregate principal amount of our 6.875% senior unsecured notes due 2031; and
- $76 million of distributions paid to noncontrolling interests.

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Net cash provided by operating activities was $461 million in the six months ended June 30, 2018 compared to $401 million in the six months ended June 30, 2017. Key factors contributing to the change between the 2018 and 2017 periods include the following:

- Increased cash receipts of $68 million related to the California provider fee program;

- Additional interest payments of $33 million in the 2018 period primarily due to the six-month interest payment in January 2018 related to our 7.500% senior secured second lien notes due 2022, which were issued in December 2016; changes in the timing of certain interest payments as a result of our refinancing transactions in 2017 also impacted the year-over-year comparison;

- Increased cash flows from our health plan businesses of $59 million due to cash outflows in the 2017 period resulting from the sales and wind-down of these businesses in 2017, compared to negligible cash flows in the 2018 period; and

- The timing of other working capital items.

FORWARD-LOOKING STATEMENTS

This report includes “forward-looking statements” within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, 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 risks described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

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

SOURCES OF REVENUE FOR OUR HOSPITAL OPERATIONS AND OTHER SEGMENT

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

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

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Net Patient Revenues Less Implicit Price Concessions and Provision for Doubtful Accounts from:	Three Months Ended June 30,			Six Months Ended June 30,		
	2018	2017	Increase (Decrease)(1)	2018	2017	Increase (Decrease)(1)
Medicare	20.4%	22.0%	(1.6)%	20.9%	22.6%	(1.7)%
Medicaid	9.1 %	7.5 %	1.6 %	9.0 %	7.4 %	1.6 %
Managed care(2)	66.0%	65.9%	0.1 %	65.5%	65.6%	(0.1)%
Self-pay	0.2 %	0.5 %	(0.3)%	0.6 %	0.4 %	0.2 %
Indemnity and other	4.3 %	4.1 %	0.2 %	4.0 %	4.0 %	— %

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

(2) Includes Medicare and Medicaid managed care programs.

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

Admissions from:	Three Months Ended June 30,			Six Months Ended June 30,		
	2018	2017	Increase (Decrease)(1)	2018	2017	Increase (Decrease)(1)
Medicare	25.3%	25.9%	(0.6)%	26.1%	26.5%	(0.4)%
Medicaid	6.2 %	6.5 %	(0.3)%	6.2 %	6.5 %	(0.3)%
Managed care(2)	59.8%	59.7%	0.1 %	59.4%	59.3%	0.1 %
Self-pay	6.1 %	5.5 %	0.6 %	5.7 %	5.4 %	0.3 %
Indemnity and other	2.6 %	2.4 %	0.2 %	2.6 %	2.3 %	0.3 %

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

(2) Includes Medicare and

Medicaid managed care programs.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services, an agency of the U.S. Department of Health and Human Services ("HHS"), is the single largest payer of healthcare services in the United States. Approximately 57 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 administered 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. Unlike Medicaid, the CHIP is limited in duration and requires the enactment of reauthorizing legislation. During the three months ended March 31, 2018, separate pieces of legislation were enacted extending CHIP funding for a total of ten years from federal fiscal year ("FFY") 2018 (which began on October 1, 2017) through FFY 2027.

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 the hospitals and related outpatient facilities in our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the three and six months ended June 30, 2018 and 2017 are set forth in the following table:

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	Three Months Ended June 30,		Six Months Ended June 30,	
Revenue Descriptions	2018	2017	2018	2017
Medicare severity-adjusted diagnosis-related group — operating	$373	$410	$797	$860
Medicare severity-adjusted diagnosis-related group — capital	34	37	72	78
Outliers	21	22	48	43
Outpatient	189	192	383	393
Disproportionate share	56	68	114	139
Direct Graduate and Indirect Medical Education(1)	47	65	103	131
Other(2)	(20)	12	(37)	12
Adjustments for prior-year cost reports and related valuation allowances	1	14	3	26
Total Medicare net patient revenues	$701	$820	$1,483	$1,682

(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 (which was divested in

2017), 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 in our Annual Report. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found under “Regulatory and Legislative Changes” below.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies 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 19.4% of total net patient revenues less implicit price concessions and provision for doubtful accounts of our hospitals and related outpatient facilities for both of the six months ended June 30, 2018 and 2017. We also receive disproportionate share hospital (“DSH”) and other supplemental revenues under various state Medicaid programs. For the six months ended June 30, 2018 and 2017, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately $418 million and $322 million, respectively. The 2018 period included $133 million related the Michigan provider fee program, $127 million from the California provider fee program, $75 million related to Medicaid DSH programs in multiple states, $54 million related to the Texas 1115 waiver program, and $29 million from a number of other state and local programs.

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

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 the hospitals and related outpatient facilities in our Hospital Operations and other segment from Medicaid-related programs in the states in which our facilities are (or were, as the case may be) located, as well as from Medicaid programs in neighboring states, for the six months ended June 30, 2018 and 2017 are set forth in the following table:

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	Six Months Ended June 30,			
	2018		2017	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Alabama	$45	$ —	$44	$ —
Arizona	(4)	82	2	99
California	215	218	84	217
Florida	42	80	39	87
Georgia	(1)	—	—	—
Illinois	30	27	36	35
Massachusetts	24	22	15	25
Michigan	195	161	184	172
Missouri	—	—	1	1
Pennsylvania	2	7	39	106
South Carolina	10	17	7	17
Tennessee	2	16	2	16
Texas	75	111	101	115
	$635	$ 741	$554	$ 890

Regulatory and Legislative Changes

Material updates to the information set forth in our Annual Report about the Medicare and Medicaid payment systems are provided below.

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year. On August 2, 2018, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2019 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.9% for 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 proposing certain adjustments to the 2.9% market basket increase that result in a net operating payment update of 1.85% (before budget neutrality adjustments), including:

- Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.8%, respectively; and

- A 0.5% increase required under the 21st Century Cures Act;

- Updates to the three factors used to determine the amount and distribution of Medicare uncompensated care disproportionate share ("UC-DSH") payments, including the continuation of the transition from using low-income days to estimated uncompensated care costs for the distribution of the UC-DSH amounts;

- A 1.27% net increase in the capital federal MS-DRG rate;

- A decrease in the cost outlier threshold from $26,537 to $25,769;

- The application of the Medicare IPPS post-acute transfer payment policy to “early discharges” from the hospital to hospice care as required by the Bipartisan Budget Act of 2018; and

- Effective January 1, 2019, the requirement that hospitals make available to the public a list of their current standard charges via the Internet in a machine-readable format and update this information at least annually or more often as appropriate.

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According to CMS, the combined impact of the payment and policy changes in the Final IPPS Rule for operating costs will yield an average 2.5% increase in Medicare operating MS-DRG fee-for-service ("FFS") payments for hospitals in large urban areas (populations over one million), and an average 2.1% increase in operating MS-DRG FFS payments for proprietary hospitals in FFY 2019. We estimate that all of the payment and policy changes affecting operating MS-DRG payments, including those affecting Medicare DSH amounts and the hospice transfer payment policy, will result in an estimated 2.0% increase in our annual Medicare FFS IPPS payments, which yields an estimated increase of approximately $40 million. Because of the uncertainty associated with various factors that may influence our future IPPS payments by individual hospital, including legislative or legal actions, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

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

On July 25, 2018, CMS released proposed policy changes and payment rates for the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year 2019 ("Proposed OPPS/ASC Rule"). The Proposed OPPS/ASC rule includes the following:

- An estimated net increase of 1.25% for the OPPS rates based on an estimated market basket increase of 2.8% reduced by market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.8%, respectively;

- The payment of Medicare physician fee schedule rates for clinic/office visits provided at off-campus, hospital-based departments that are currently paid under the OPPS (as proposed, this payment adjustment would not be made in a budget-neutral manner and would result in a reduction of approximately 1.2% to total OPPS payments); and

- A 2.0% update to the ASC payment rates.

CMS projects that the combined impact of the payment and policy changes in the Proposed OPPS/ASC Rule will yield an average 0.1% decrease in Medicare FFS OPPS payments for all hospitals, an average 0.1% increase in Medicare FFS OPPS payments for hospitals in large urban areas (populations over one million), and an average 0.7% increase in Medicare FFS OPPS payments for proprietary hospitals. Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Proposed OPPS/ASC Rule on our hospitals is an increase to Medicare FFS hospital outpatient revenues of approximately $3 million, which represents an increase of approximately 0.5%. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative or legal actions, volumes and case mix, as well as potential changes to the proposed rule, we cannot provide any assurances regarding our estimate of the impact of the proposed changes.

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, including Medicare and Medicaid managed care programs, from our Hospital Operations and other segment during the six months ended June 30, 2018 and 2017 was $4.641 billion and $4.884 billion, respectively. Approximately 64% of our managed care net patient revenues for the six months ended

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June 30, 2018 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 June 30, 2018 and December 31, 2017, approximately 63% and 62%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and 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 June 30, 2018, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $14 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage and payment levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. 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 benefited from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate in recent years, and we believe the moderation could continue in future years. In the six months ended June 30, 2018, our commercial managed care net inpatient revenue per admission from our acute care and specialty hospitals was approximately 96% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

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

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs, 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. Approximately 6% of our net accounts receivable for our Hospital Operations and other segment was due from self-pay patients at both June 30, 2018 and December 31, 2017. Further, a significant portion of our implicit price concessions relates to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. We provide revenue cycle management services through Conifer, which is subject to various statutes and regulations regarding consumer protection in areas including finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, in Part I of our Annual Report.

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

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

We also provide charity care to patients who are 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, which exclude the costs of our health plan businesses) of caring for self-pay patients and charity care patients, as well as revenues attributable to Medicaid DSH and other supplemental revenues we recognized, in the three and six months ended June 30, 2018 and 2017:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Estimated costs for:				
Self-pay patients	$159	$160	$305	$320
Charity care patients	28	33	63	63
Total	$187	$193	$368	$383
Medicaid DSH and other supplemental revenues	$198	$164	$418	$322

The expansion of health insurance coverage in prior periods has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand

Medicaid coverage and for persons living in the country illegally who are not permitted to enroll in a health insurance exchange or government healthcare insurance program. Furthermore, in October 2017, the Trump administration announced that reimbursements to insurance companies for ACA cost-sharing reduction ("CSR") plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, some insurers may seek approval to increase premiums for plans offered on ACA exchanges or withdraw from offering plans on some or all of the exchanges. We cannot predict what actions insurers might take as a result of the order, the impact of those actions on our operations, or the outcome of legislative efforts or litigation seeking to restore the payments. We also do not know what adverse impact the continued uncertainty may have on marketplace enrollment and coverage.

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RESULTS OF OPERATIONS

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the three and six months ended June 30, 2018 and 2017:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Net operating revenues:				
Hospital Operations and other	$3,733	$4,445	$7,680	$8,936
Ambulatory Care	531	483	1,029	945
Conifer	386	400	790	802
Inter-segment eliminations	(144)	(155)	(294)	(314)
Net operating revenues before provision for doubtful accounts	4,506	5,173	9,205	10,369
Less provision for doubtful accounts	—	371	—	754
Net operating revenues	4,506	4,802	9,205	9,615
Equity in earnings of unconsolidated affiliates	39	28	64	57
Operating expenses:				
Salaries, wages and benefits	2,135	2,346	4,362	4,726
Supplies	748	780	1,522	1,545
Other operating expenses, net	1,027	1,159	2,087	2,346
Electronic health record incentives	—	(6)	(1)	(7)
Depreciation and amortization	194	222	398	443
Impairment and restructuring charges, and acquisition-related costs	30	41	77	74
Litigation and investigation costs	13	1	19	6
Net gains on sales, consolidation and deconsolidation of facilities	(8)	(23)	(118)	(38)
Operating income	$406	$310	$923	$577

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Net operating revenues	100.0 %	100.0 %	100.0 %	100.0 %
Equity in earnings of unconsolidated affiliates	0.9 %	0.6 %	0.7 %	0.6 %
Operating expenses:				
Salaries, wages and benefits	47.4 %	48.9 %	47.5 %	49.2 %
Supplies	16.6 %	16.2 %	16.5 %	16.1 %
Other operating expenses, net	22.8 %	24.1 %	22.7 %	24.4 %
Electronic health record incentives	— %	(0.1)%	— %	(0.1)%
Depreciation and amortization	4.3 %	4.6 %	4.3 %	4.6 %
Impairment and restructuring charges, and acquisition-related costs	0.7 %	0.9 %	0.8 %	0.8 %
Litigation and investigation costs	0.3 %	— %	0.2 %	0.1 %
Net gains on sales, consolidation and deconsolidation of facilities	(0.2)%	(0.5)%	(1.3)%	(0.4)%
Operating income	9.0 %	6.5 %	10.0 %	6.0 %

Total net operating revenues decreased by $296 million and $410 million, or 6.2% and 4.3%, for the three and six months ended June 30, 2018, respectively, compared to the three and six months ended June 30, 2017, respectively. Hospital Operations and other and Ambulatory Care net operating revenues and provision for doubtful accounts were impacted by our adoption of ASU 2014-09 effective January 1, 2018. Prior to the adoption of ASU 2014-09, a

significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding material reduction in the amounts presented separately as provision for doubtful accounts. Hospital Operations and other net operating revenues net of implicit price concessions and provision for doubtful accounts decreased by $352 million and $520 million, or 8.6% and 6.3%, for the three and six months ended June 30, 2018, respectively, compared to the three and six months ended June 30, 2017, respectively, primarily due to the divestiture or closure of eight hospitals since the 2017 period, as well as decreased revenues from our health plans, most of which were sold or winding down in 2017. The three and six months ended June 30, 2018 included $63 million and $127 million, respectively, of net revenues from the California provider fee program compared to no revenue recorded under this program in the 2017 periods because the extension of the program had not yet been approved by CMS. Ambulatory Care net operating revenues net of implicit price concessions and provision for doubtful

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accounts increased $59 million and $102 million, or 12.5% and 11.0%, for the three and six months ended June 30, 2018, respectively, compared to the three and six months ended June 30, 2017, respectively. The changes were driven by increases in same-facility net operating revenues of $43 million and $70 million for the three and six month periods, respectively, and increases from acquisitions of $16 million and $32 million for the three and six month periods, respectively. Conifer net operating revenues decreased $14 million and $12 million, or 3.5% and 1.5% for the three and six month periods, respectively.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 68 hospitals operated throughout the six months ended June 30, 2018 and 2017. The results of three Houston-area hospitals, which we divested effective August 1, 2017, Abrazo Maryvale Campus, which we closed in December 2017, two Philadelphia-area hospitals, which we divested effective January 11, 2018, MacNeal Hospital, which we divested effective March 1, 2018, and Des Peres Hospital, which we divested effective May 1, 2018, are excluded from our same-hospital information. In addition, although we operated four North Texas hospitals throughout the six months ended June 30, 2017 and from January 1 through February 28, 2018, we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

	Three Months Ended June 30,			Six Months Ended June 30,		
Selected Operating Expenses	2018	2017	Increase (Decrease)	2018	2017	Increase (Decrease)
Hospital Operations and other — Same-Hospital						
Salaries, wages and benefits	$1,752	$1,732	1.2 %	$3,548	$3,496	1.5 %
Supplies	638	619	3.1 %	1,286	1,223	5.2 %
Other operating expenses	847	834	1.6 %	1,696	1,691	0.3 %
Total	$3,237	$3,185	1.6 %	$6,530	$6,410	1.9 %
Ambulatory Care						
Salaries, wages and benefits	$165	$153	7.8 %	$327	$303	7.9 %
Supplies	106	96	10.4 %	212	190	11.6 %
Other operating expenses	95	89	6.7 %	187	174	7.5 %
Total	$366	$338	8.3 %	$726	$667	8.8 %
Conifer						
Salaries, wages and benefits	$214	$250	(14.4)%	$439	$500	(12.2)%
Supplies	1	2	(50.0)%	3	2	50.0 %
Other operating expenses	80	88	(9.1)%	159	175	(9.1)%
Total	$295	$340	(13.2)%	$601	$677	(11.2)%
Total						
Salaries, wages and benefits	$2,131	$2,135	(0.2)%	$4,314	$4,299	0.3 %
Supplies	745	717	3.9 %	1,501	1,415	6.1 %
Other operating expenses	1,022	1,011	1.1 %	2,042	2,040	0.1 %
Total	$3,898	$3,863	0.9 %	$7,857	$7,754	1.3 %
Rent/lease expense(1)						
Hospital Operations and other	$56	$55	1.8 %	$114	$110	3.6 %
Ambulatory Care	20	19	5.3 %	40	37	8.1 %
Conifer	5	5	— %	9	10	(10.0)%
Total	$81	$79	2.5 %	$163	$157	3.8 %

(1) Included in other operating

expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported in three segments:

- Hospital Operations and other, which is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 4 to the accompanying Condensed Consolidated Financial Statements, certain of our facilities are classified as held for sale at June 30, 2018.
- Ambulatory Care, which is comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals, as well as Aspen's hospitals and clinics, which are classified as held for sale at June 30, 2018 as described in Note 4 to the accompanying Condensed Consolidated Financial Statements.

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

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals and related outpatient facilities on a same-hospital basis, unless otherwise indicated, which includes the results of our same 68 hospitals operated throughout the six months ended June 30, 2018 and 2017. The results of three Houston-area hospitals, which we divested effective August 1, 2017, Abrazo Maryvale Campus, which we closed in December 2017, two Philadelphia-area hospitals, which we divested effective January 11, 2018, MacNeal Hospital, which we divested effective March 1, 2018, and Des Peres Hospital, which we divested effective May 1, 2018, are excluded from our same-hospital information. In addition, although we operated four North Texas hospitals throughout the six months ended June 30, 2017 and from January 1 through February 28, 2018, we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

	Same-Hospital Continuing Operations Three Months Ended June 30,				Same-Hospital Continuing Operations Six Months Ended June 30,			
Admissions, Patient Days and Surgeries	2018	2017	Increase (Decrease)		2018	2017	Increase (Decrease)	
Number of hospitals (at end of period)	68	68	—	(1)	68	68	—	(1)
Total admissions	168,135	172,048	(2.3)%		346,324	349,672	(1.0)%	
Adjusted patient admissions(2)	305,541	306,278	(0.2)%		617,838	616,415	0.2 %	
Paying admissions (excludes charity and uninsured)	157,904	162,630	(2.9)%		326,458	331,153	(1.4)%	
Charity and uninsured admissions	10,231	9,418	8.6 %		19,866	18,519	7.3 %	
Admissions through emergency department	114,945	110,486	4.0 %		237,867	225,253	5.6 %	
Paying admissions as a percentage of total admissions	93.9 %	94.5 %	(0.6)%	(1)	94.3 %	94.7 %	(0.4)%	(1)
Charity and uninsured admissions as a percentage of total admissions	6.1 %	5.5 %	0.6 %	(1)	5.7 %	5.3 %	0.4 %	(1)
Emergency department admissions as a percentage of total admissions	68.4 %	64.2 %	4.2 %	(1)	68.7 %	64.4 %	4.3 %	(1)
Surgeries — inpatient	46,057	47,288	(2.6)%		91,997	94,188	(2.3)%	
Surgeries — outpatient	63,615	63,642	— %		124,664	125,754	(0.9)%	
Total surgeries	109,672	110,930	(1.1)%		216,661	219,942	(1.5)%	
Patient days — total	765,659	792,160	(3.3)%		1,606,445	1,625,921	(1.2)%	
Adjusted patient days(2)	1,372,048	1,390,154	(1.3)%		2,820,404	2,824,012	(0.1)%	
Average length of stay (days)	4.55	4.60	(1.1)%		4.64	4.65	(0.2)%	
Licensed beds (at end of period)	17,946	17,980	(0.2)%		17,946	17,980	(0.2)%	
Average licensed beds	17,946	17,980	(0.2)%		17,946	17,972	(0.1)%	
Utilization of licensed beds(3)	46.9 %	48.4 %	(1.5)%	(1)	49.5 %	50.0 %	(0.5)%	(1)

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

amounts shown.

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

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

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Outpatient Visits	Same-Hospital Continuing Operations Three Months Ended June 30, 2018	2017	Increase (Decrease)	Same-Hospital Continuing Operations Six Months Ended June 30, 2018	2017	Increase (Decrease)
Total visits	1,748,312	1,766,625	(1.0)%	3,542,213	3,577,426	(1.0)%
Paying visits (excludes charity and uninsured)	1,631,963	1,652,532	(1.2)%	3,312,212	3,351,449	(1.2)%
Charity and uninsured visits	116,349	114,093	2.0 %	230,001	225,977	1.8 %
Emergency department visits	642,623	645,803	(0.5)%	1,325,226	1,296,580	2.2 %
Surgery visits	63,615	63,642	— %	124,664	125,754	(0.9)%
Paying visits as a percentage of total visits	93.3 %	93.5 %	(0.2)% (1)	93.5 %	93.7 %	(0.2)% (1)
Charity and uninsured visits as a percentage of total visits	6.7 %	6.5 %	0.2 % (1)	6.5 %	6.3 %	0.2 % (1)

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

Revenues	Same-Hospital Continuing Operations Three Months Ended June 30, 2018	2017	Increase (Decrease)	Same-Hospital Continuing Operations Six Months Ended June 30, 2018	2017	Increase (Decrease)
Total segment net operating revenues(1)	$3,579	$3,470	3.1 %	$7,286	$6,983	4.3 %
Selected revenue data – hospitals and related outpatient facilities						
Net patient revenues(1)(2)	$3,432	$3,325	3.2 %	$7,002	$6,668	5.0 %
Net patient revenue per adjusted patient admission(1)(2)	$11,233	$10,856	3.5 %	$11,333	$10,817	4.8 %
Net patient revenue per adjusted patient day(1)(2)	$2,501	$2,392	4.6 %	$2,483	$2,361	5.2 %

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

(2) Adjusted patient admissions/days

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

Total Segment Selected Operating Expenses	Same-Hospital Continuing Operations Three Months Ended June 30,			Same-Hospital Continuing Operations Six Months Ended June 30,		
	2018	2017	Increase (Decrease)	2018	2017	Increase (Decrease)
Salaries, wages and benefits as a percentage of net operating revenues	49.0%	49.9%	(0.9)% (1)	48.7%	50.1%	(1.4)% (1)
Supplies as a percentage of net operating revenues	17.8%	17.8%	— % (1)	17.7%	17.5%	0.2 % (1)
Other operating expenses as a percentage of net operating revenues	23.7%	24.0%	(0.3)% (1)	23.3%	24.2%	(0.9)% (1)

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

Revenues

Same-hospital net operating revenues increased $109 million, or 3.1%, during the three months ended June 30, 2018 compared to the three months ended June 30, 2017, primarily due improved terms of our managed care contracts and

California provider fee revenues. The 2018 period included $63 million of net revenues from the California provider fee program compared to no revenue recorded under this program in the 2017 period because the extension of the program had not yet been approved by CMS. Same-hospital admissions decreased 2.3% in the three months ended June 30, 2018 compared to the same period in 2017. Same-hospital outpatient visits decreased 1.0% in the three months ended June 30, 2018 compared to the same period in 2017 due in part to the sale of home health and hospice assets.

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Same-hospital net operating revenues increased $303 million, or 4.3%, during the six months ended June 30, 2018 compared to the six months ended June 30, 2017, primarily due improved terms of our managed care contracts and California provider fee revenues. The 2018 period included $127 million of net revenues from the California provider fee program compared to no revenue recorded under this program in the 2017 period because the extension of the program had not yet been approved by CMS. Same-hospital admissions decreased 1.0% in the six months ended June 30, 2018 compared to the same period in 2017. Same-hospital outpatient visits decreased 1.0% in the six months ended June 30, 2018 compared to the same period in 2017 due in part to the sale of home health and hospice assets.

The following table shows the consolidated net accounts receivable by payer at June 30, 2018 and the consolidated net accounts receivable and allowance for doubtful accounts by payer at December 31, 2017:

	June 30, 2018	December 31, 2017		
	Accounts Receivable	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 200	$257	$ —	$257
Medicaid	97	95	—	95
Net cost report settlements receivable and valuation allowances	1	4	—	4
Managed care	1,454	1,709	204	1,505
Self-pay uninsured	47	407	351	56
Self-pay balance after insurance	101	240	149	91
Estimated future recoveries	110	132	—	132
Other payers	309	453	151	302
Total Hospital Operations and other	2,319	3,297	855	2,442
Ambulatory Care	162	215	43	172
Total discontinued operations	2	2	—	2
	$ 2,483	$3,514	$ 898	$2,616

For patient accounts receivable resulting from revenue recognized prior to January 1, 2018, an allowance for doubtful accounts was established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimated this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. Under the provisions of ASU 2014-09, which we adopted effective January 1, 2018, when we have an unconditional right to payment, subject only to the passage of time, the right is treated as a receivable. Patient accounts receivable, including billed accounts and unbilled accounts for which we have the unconditional right to payment, and estimated amounts due from third-party payers for retroactive adjustments, are receivables if our right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. For patient accounts receivable subsequent to our adoption of ASU 2014-09 on January 1, 2018, the estimated uncollectable amounts are generally considered implicit price concessions that are a direct reduction to patient accounts receivable rather than allowance for doubtful accounts. Under the provisions of ASU 2014-09, amounts related to services provided to patients for which we have not billed and that do not meet the conditions of unconditional right to payment at the end of the reporting period are contract assets. For our Hospital Operations and other segment, our contract assets consist primarily of services that we have provided to patients who are still receiving inpatient care in our facilities at the end of the reporting period. Our Hospital Operations and other segment’s contract assets are included in other current assets on the accompanying

Condensed Consolidated Balance Sheet at June 30, 2018. Prior to January 1, 2018, amounts related to services provided to patients for which we had not billed were included in accounts receivable, less allowance for doubtful accounts, on our consolidated balance sheets.

Collection of accounts receivable has been a key area of focus, particularly over the past several years. At June 30, 2018, our Hospital Operations and other segment collection rate on self-pay accounts was approximately 23.6%. Our self-pay collection rate includes payments made by patients, including co-pays, co-insurance amounts and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays, co-insurance amounts and deductibles owed to us by patients with insurance at June 30, 2018, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to patient accounts receivable of approximately $12 million.

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Payment pressure from managed care payers also affects the collectability of our accounts receivable. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated Hospital Operations and other segment collection rate from managed care payers was approximately 98.6% at June 30, 2018.

We manage our implicit price concessions using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) AR Days and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations and other segment of $2.318 billion and $2.438 billion at June 30, 2018 and December 31, 2017, respectively, excluding cost report settlements receivable and valuation allowances of $1 million and $4 million, respectively, at June 30, 2018 and December 31, 2017:

	June 30, 2018									
	Medicare		Medicaid		Managed Care		Indemnity, Self-Pay and Other		Total	
0-60 days(1)	88	%	54	%	58	%	27	%	54	%
61-120 days	6	%	26	%	16	%	17	%	15	%
121-180 days	3	%	7	%	9	%	11	%	9	%
Over 180 days	3	%	13	%	17	%	45	%	22	%
Total	100	%	100	%	100	%	100	%	100	%

(1) The 0-60 days aging category has been impacted by the reclassification of certain unbilled accounts to contract assets due to the adoption of ASU 2014-09 effective January 1, 2018. See Notes 1 and 3 to our accompanying Condensed Consolidated Financial Statements for additional information.

	December 31, 2017				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay	Total

					and Other			
0-60 days	89 %	66 %	65 %	28 %	60 %			
61-120 days	6 %	16 %	14 %	17 %	13 %			
121-180 days	2 %	10 %	7 %	9 %	7 %			
Over 180 days	3 %	8 %	14 %	46 %	20 %			
Total	100%	100 %	100 %	100 %	100%			

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

At June 30, 2018, we had a cumulative total of patient account assignments to Conifer of approximately $2.462 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to Conifer is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer’s Medicaid Eligibility Program (“MEP”) screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. Based on recent trends, approximately 97% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at June 30, 2018 and December 31, 2017 by aging category for the hospitals currently in the program:

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	June 30, 2018	December 31, 2017
0-60 days	$ 64	$ 81
61-120 days	12	12
121-180 days	3	3
Over 180 days	3	4
Total	$ 82	$ 100

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased 90 basis points to 49.0% in the three months ended June 30, 2018 compared to the same period in 2017. Same-hospital net operating revenues increased 3.1% during the three months ended June 30, 2018 compared to the three months ended June 30, 2017, and same-hospital salaries, wages and benefits increased 1.2% in the three months ended June 30, 2018 compared to the 2017 period. The change in same-hospital salaries, wages and benefits as a percentage of net operating revenues was primarily due to the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives, partially offset by annual merit increases for certain of our employees and increased health benefits costs. Salaries, wages and benefits expense for the three months ended June 30, 2018 and 2017 included stock-based compensation expense of $8 million and $13 million, respectively.

Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased 140 basis points to 48.7% in the six months ended June 30, 2018 compared to the same period in 2017. Same-hospital net operating revenues increased 4.3% during the six months ended June 30, 2018 compared to the six months ended June 30, 2017, and same-hospital salaries, wages and benefits increased 1.5% in the six months ended June 30, 2018 compared to the 2017 period. The change in same-hospital salaries, wages and benefits as a percentage of net operating revenues was primarily due to the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives, partially offset by annual merit increases for certain of our employees and increased health benefits costs. Salaries, wages and benefits expense for the six months ended June 30, 2018 and 2017 included stock-based compensation expense of $13 million and $22 million, respectively.

At June 30, 2018, approximately 25% of the employees in our Hospital Operations and other segment were represented by labor unions. Less than 1% of employees in our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 33 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have 12 expired contracts covering approximately 22% of our unionized employees and are or will be negotiating renewals under extension agreements. We are also negotiating (or will soon negotiate) six first contracts at six hospitals where employees recently selected union representation; these contracts will cover nearly 7% of our unionized employees. 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 was 17.8% for both of the three month periods ended June 30, 2018 and 2017. Same-hospital supplies expense as a percentage of net operating revenues increased 20 basis points to 17.7% for the six months ended June 30, 2018 compared to the six months ended June 30, 2017. Supplies expense was impacted by increased costs from certain higher acuity supply-intensive surgical services.

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.

Other Operating Expenses, Net

Same-hospital other operating expenses as a percentage of net operating revenues decreased 30 basis points to 23.7% in the three months ended June 30, 2018 compared to 24.0% in the same period in 2017. Same-hospital other operating expenses increased by $13 million, or 1.6%, and net operating revenues increased by $109 million, or 3.1%, for the three

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months ended June 30, 2018 compared to the three months ended June 30, 2017. The changes in other operating expenses included:

- decreased expenses associated with our health plan businesses of $41 million due to the sale and wind-down of these businesses in 2017; and
- decreased malpractice expense of $8 million; partially offset by
- increased medical fees of $16 million; and
- gains on the sales of assets of $23 million in the 2017 period primarily related to the sale of home health and hospice assets.

Same-hospital malpractice expense in the 2018 period included a favorable adjustment of approximately $3 million from the 13 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities. In the 2017 period, we recognized an unfavorable adjustment of approximately $2 million from the eight basis point decrease in the discounted present value of projected future malpractice liabilities.

Same-hospital other operating expenses as a percentage of net operating revenues decreased 90 basis points to 23.3% in the six months ended June 30, 2018 compared to 24.2% in the same period in 2017. Same-hospital other operating expenses increased by $5 million, or 0.3%, and net operating revenues increased by $303 million, or 4.3%, for the six months ended June 30, 2018 compared to the six months ended June 30, 2017. The changes in other operating expenses included:

- decreased expenses associated with our health plan businesses of $112 million due to the sale and wind-down of these businesses in 2017; partially offset by
- increased malpractice expense of $11 million;
- increased medical fees of $26 million; and
- gains on the sales of assets of $23 million in the 2017 period primarily related to the sale of home health and hospice assets.

Same-hospital malpractice expense in the 2018 period included a favorable adjustment of approximately $13 million from the 48 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities. In the 2017 period, we recognized an unfavorable adjustment of approximately $2 million from the 11 basis point decrease in the discounted present value of projected future malpractice liabilities.

Ambulatory Care Segment

Our Ambulatory Care segment is comprised of USPI's ambulatory surgery centers, urgent care centers, imaging centers and surgical hospitals, as well as Aspen's hospitals and clinics. USPI operates its surgical facilities in partnership with local physicians and, in many of these facilities, a healthcare system partner. We hold an ownership interest in each facility, with each being operated through a separate legal entity in most cases. 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 implicit price concessions); and
- our share of each facility's net income (loss), which is computed by multiplying the facility's net income (loss) times the percentage of each facility's equity interests owned by USPI.

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. In many of the facilities our Ambulatory Care segment operates (110 of 342 facilities at June 30, 2018), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method for an unconsolidated affiliate. USPI controls 232 of the facilities our Ambulatory Care segment operates, and we account for these investments as consolidated subsidiaries. Our net earnings from a facility are the same under either method, but the classification of those earnings differs. For consolidated subsidiaries, our financial statements reflect 100% of the revenues and expenses of the subsidiaries, after the elimination of intercompany amounts. The net profit attributable to owners other than USPI is classified within “net income available to noncontrolling interests.”

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

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

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

Our Ambulatory Care segment operating income is driven by the performance of all facilities USPI operates and by the joint venture's ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 68% of those facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses.

Results of Operations

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

	Three Months Ended June 30,			Six Months Ended June 30,		
Ambulatory Care Results of Operations	2018	2017	Increase	2018	2017	Increase
Net operating revenues	$531	$472	12.5 %	$1,029	$927	11.0 %
Equity in earnings of unconsolidated affiliates	$33	$30	10.0 %	$60	$57	5.3 %
Salaries, wages and benefits	$165	$153	7.8 %	$327	$303	7.9 %
Supplies	$106	$96	10.4 %	$212	$190	11.6 %
Other operating expenses, net	$95	$89				