TENET HEALTHCARE CORP
Form 10-K
February 23, 2010
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-K

x Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2009

OR

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

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

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

1445 Ross Avenue, Suite 1400

Dallas, TX 75202

(Address of principal executive offices, including zip code)

(469) 893-2200

(Registrant s telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common stock	New York Stock Exchange
6 3/8% Senior Notes due 2011	New York Stock Exchange
6 1/2% Senior Notes due 2012	New York Stock Exchange
7 3/8% Senior Notes due 2013	New York Stock Exchange
9 7/8% Senior Notes due 2014	New York Stock Exchange
9 1/4% Senior Notes due 2015	New York Stock Exchange
6 7/8% Senior Notes due 2031	New York Stock Exchange

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

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ¨

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 and posted on its corporate website every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes ¨ No ¨

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

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

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

As of June 30, 2009, there were 480,816,199 shares of common stock, $0.05 par value, outstanding. The aggregate market value of the shares of common stock held by non-affiliates of the Registrant as of June 30, 2009, based on the closing price of the Registrant s shares on the New York Stock Exchange on that day, was approximately $1,116,922,242. For the purpose of the foregoing calculation only, all directors and the executive officers who were SEC reporting persons of the Registrant as of June 30, 2009 have been deemed affiliates. As of January 29, 2010, there were 481,148,392 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s definitive proxy statement for the 2010 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

Table of Contents

TABLE OF CONTENTS

Table of Contents

PART I.

ITEM 1. BUSINESS
DESCRIPTION OF BUSINESS

Tenet Healthcare Corporation is an investor-owned health care services company whose subsidiaries and affiliates principally operate general hospitals and related ancillary health care businesses. All of Tenet s operations are conducted through its subsidiaries. (Unless the context otherwise requires, Tenet and its subsidiaries are referred to herein as Tenet, the Company, we or us.) At December 31, 2009, our subsidiaries operated 50 general hospitals (including one hospital not yet divested at that date that is classified in discontinued operations in our Consolidated Financial Statements) and a critical access hospital, with a combined total of 13,601 licensed beds, serving urban and rural communities in 12 states. Of those general hospitals, 45 were owned by our subsidiaries and five were owned by third parties and leased by our subsidiaries.

At December 31, 2009, our subsidiaries also operated various related health care facilities, including a long-term acute care hospital, outpatient surgery centers, diagnostic imaging centers, occupational and rural health care clinics, and a number of medical office buildings (all of which are located on, or nearby, one of our general hospital campuses). In addition, our subsidiaries operated physician practices and captive insurance companies and owned an interest in a health maintenance organization, all of which comprise a minor portion of our business.

Our hospitals and related health care facilities are committed to providing high quality care to patients in the communities we serve. To accomplish this mission in the complex and competitive health care industry, our operating strategies are to (1) identify best practices in evidence-based medicine and implement those best practices in all of our hospitals, (2) maintain high standards of ethics and compliance, (3) improve operating efficiencies and control operating costs while maintaining or improving the quality of care provided, (4) improve patient, physician and employee satisfaction, (5) improve recruitment and retention of physicians, as well as nurses and other employees, (6) increase collections of accounts receivable and increase cash flow to fund improvements at our hospitals, and (7) build or acquire new, or divest existing, facilities as market conditions, operational goals and other considerations warrant. We adjust these strategies as necessary in response to changes in the economic and regulatory climates in which we operate and the success or failure of our various efforts.

OPERATIONS

Our continuing operations are structured as follows:

- Our California region includes all of our hospitals in California, as well as our hospital in Nebraska;
- Our Central region includes all of our hospitals in Missouri, Tennessee and Texas;
- Our Florida region includes all of our hospitals in Florida;
- Our Southern States region includes all of our hospitals in Alabama, Georgia, North Carolina and South Carolina; and
- Our two hospitals in Philadelphia, Pennsylvania are part of a separate market.

Each of the regions and the market described above report directly to our chief operating officer. Major decisions, including capital resource allocations, are made at the corporate level, not at the regional or hospital level.

We seek to operate our hospitals in a manner that positions them to compete effectively in an evolving health care environment. To that end, we sometimes decide to sell, consolidate or close certain facilities in order to eliminate duplicate services or excess capacity, or because of changing market conditions. Of the three general hospitals and one cancer hospital that were classified as held for sale at December 31, 2008, we completed the sale of USC University Hospital and USC Kenneth Norris Jr. Cancer Hospital on March 31, 2009. In addition, we closed Irvine

Regional Hospital and Medical Center in January 2009 before the expiration of our lease in February 2009, and we closed Community Hospital of Los Gatos and terminated our lease in April 2009. In May 2009, we announced that we would not renew our operating lease agreement for NorthShore Regional Medical Center, located in Slidell, Louisiana, which lease expires in May 2010. Accordingly, the hospital was reclassified into discontinued operations in the three months ended June 30, 2009. In January 2010, we entered into a definitive agreement to sell certain of our owned assets associated with NorthShore and transition the operation of the hospital to a new hospital operator. We anticipate that the transaction will close effective April 1, 2010, at which time we will terminate our lease of the hospital.

Table of Contents

From time to time, we build new hospitals, make strategic acquisitions of hospitals and other health care facilities, and enter into partnerships or affiliations with related health care businesses. Our newly constructed 140-bed replacement hospital for East Cooper Regional Medical Center in Mt. Pleasant, South Carolina is expected to open in April 2010. In addition, we are seeking to open a new acute care hospital in Fort Mill, South Carolina. Our application for a certificate of need to build the hospital was approved in May 2006, but that approval was appealed by the other applicants and, in December 2009, an administrative law judge ruled that South Carolina regulators must reconsider all of the certificate of need proposals again. We are appealing that decision; however, we are unable to predict the outcome or timing of this process. Once construction begins, the hospital is expected to take up to an additional two years to complete.

Our general hospitals in continuing operations generated in excess of 97% of our net operating revenues for all periods presented in our Consolidated Financial Statements. Factors that affect patient volumes and, thereby, our results of operations at our hospitals and related health care facilities include, but are not limited to: (1) the business environments, economic conditions and demographics of local communities; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local health care competitors; (8) managed care contract negotiations or terminations; (9) any unfavorable publicity about us, which impacts our relationships with physicians and patients; and (10) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most offer intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. A number of the hospitals also offer tertiary care services such as open-heart surgery, neonatal intensive care and neuroscience. Three of our hospitals St. Louis University Hospital, Hahnemann University Hospital and St. Christopher s Hospital for Children offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Sierra Medical Center and Good Samaritan Medical Center also offer gamma-knife brain surgery; and St. Louis University Hospital offers cyberknife surgery for tumors and lesions in the brain, lung, neck and spine that may have been previously considered inoperable or inaccessible by radiation therapy. In addition, our hospitals will continue their efforts to deliver and develop those outpatient services that can be provided on a quality, cost-effective basis and that we believe will meet the needs of the communities served by the facilities.

With the exception of our 25-bed Sylvan Grove Hospital located in Georgia, which is designated by the Centers for Medicare and Medicaid Services (CMS) as a critical access hospital and which has not sought to be accredited, each of our facilities that is eligible for accreditation is accredited by the Joint Commission (formerly, the Joint Commission on Accreditation of Healthcare Organizations), the American Osteopathic Association (in the case of one hospital) or another appropriate accreditation agency. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are, therefore, eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. The critical access hospital that is not accredited also participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation.

Table of Contents

The following table lists, by state, the general hospitals owned or leased and operated by our subsidiaries as of December 31, 2009:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	602	Owned
California			
Desert Regional Medical Center(1)	Palm Springs	367	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	465	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
John F. Kennedy Memorial Hospital	Indio	156	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	114	Owned
Florida			
Coral Gables Hospital	Coral Gables	247	Owned
Delray Medical Center	Delray Beach	493	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
North Shore Medical Center FMC Campus	Lauderdale Lakes	459	Owned
Palm Beach Gardens Medical Center(2)	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
Saint Mary s Medical Center	West Palm Beach	463	Owned
West Boca Medical Center	West Boca Raton	195	Owned
Georgia			
Atlanta Medical Center	Atlanta	460	Owned
North Fulton Regional Hospital(2)	Roswell	202	Leased
South Fulton Medical Center	East Point	338	Owned
Spalding Regional Hospital	Griffin	160	Owned
Sylvan Grove Hospital(3)	Jackson	25	Leased
Louisiana			
NorthShore Regional Medical Center(4)	Slidell	165	Leased
Missouri			
Des Peres Hospital	St. Louis	167	Owned
St. Louis University Hospital	St. Louis	356	Owned
Nebraska			
Creighton University Medical Center(5)	Omaha	334	Owned
North Carolina			
Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center(2)	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	540	Owned
St. Christopher s Hospital for Children	Philadelphia	189	Owned

Table of Contents

Hospital	Location	Licensed Beds	Status
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Regional Medical Center	Mt. Pleasant	106	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital Bartlett	Bartlett	100	Owned
Texas			
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake	Dallas	218	Owned
Houston Northwest Medical Center(6)	Houston	430	Owned
Lake Pointe Medical Center(7)	Rowlett	112	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
Park Plaza Hospital	Houston	444	Owned
Providence Memorial Hospital	El Paso	508	Owned
Sierra Medical Center	El Paso	351	Owned
Sierra Providence East Medical Center	El Paso	110	Owned

(1) Lease expires in 2027.
(2) The current lease terms for Palm Beach Gardens Medical Center, North Fulton Regional Hospital and Frye Regional Medical Center expire in February 2014, but may be renewed through at least February 2039, in each case subject to certain conditions contained in the respective leases.
(3) Designated by CMS as a critical access hospital. The current lease term for this facility expires in December 2011, but may be renewed through December 2046, subject to certain conditions contained in the lease.
(4) Reclassified into discontinued operations in the three months ended June 30, 2009. In January 2010, we entered into a definitive agreement to sell certain of our owned assets associated with NorthShore and transition the operation of the hospital to a new hospital operator. We anticipate that the transaction will close effective April 1, 2010, at which time we will terminate our lease of the hospital.
(5) Owned by a limited liability company in which a Tenet subsidiary owned a 74.06% interest at December 31, 2009 and is the managing member.
(6) Owned by a limited liability company in which a Tenet subsidiary owned an 87.62% interest at December 31, 2009 and is the managing member.
(7) Owned by a limited liability company in which a Tenet subsidiary owned a 94.63% interest at December 31, 2009 and is the managing member.

As of December 31, 2009, the largest concentrations of licensed beds in our general hospitals were in Florida (25.6%), Texas (19.3%) and California (17.0%). Strong concentrations of hospital beds within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other developments occur in these areas, our business, financial condition, results of operations or cash flows could be materially adversely affected. Only one of our individual hospitals represented more than 5% (approximately 5.1%) of our net operating revenues for the year ended December 31, 2009, and one represented more than 5% (approximately 5.5%) of our total assets, excluding goodwill and intercompany receivables, at December 31, 2009.

The following table shows certain information about the hospitals operated by our subsidiaries at December 31, 2009, 2008 and 2007.

	December 31,		
	2009	2008	2007
Total number of facilities(1)	51	54	58
Total number of licensed beds(2)	13,601	14,352	15,244

(1) Includes all general hospitals and critical access facilities, as well as one facility at December 31, 2009, four facilities at December 31, 2008 and nine facilities at December 31, 2007, respectively, that are classified in discontinued operations for financial reporting purposes as of December 31, 2009.

(2) Information regarding utilization of licensed beds and other operating statistics can be found in Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations.

Table of Contents

PROPERTIES

Description of Real Property. The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2009 are set forth in the table beginning on page 3. At December 31, 2009, our subsidiaries also owned or leased and operated 66 medical office buildings, most of which are adjacent to our general hospitals. We are currently seeking to sell up to 30 of these medical office buildings, totaling approximately 2.25 million square feet of rental space.

Our corporate headquarters are located in Dallas, Texas. We have other corporate administrative offices in Anaheim, California; Coral Springs, Florida; and Philadelphia, Pennsylvania. One of our subsidiaries leases our corporate headquarters space under an operating lease agreement that expires in December 2019. Other subsidiaries lease the space for our offices in Anaheim, Coral Springs and Philadelphia under operating lease agreements. We believe that all of our properties, including the administrative and medical office buildings described above, are suitable for their intended purposes.

Obligations Relating to Real Property. As of December 31, 2009, we had approximately $5 million of outstanding loans secured by property and equipment, and we had approximately $2 million of capital lease obligations. In addition, from time to time, we lease real property to third-party developers for the construction of medical office buildings. Under our current practice, the financing necessary to construct the medical office buildings encumbers only the leasehold and not our fee interest in the real estate. In years past, however, we have at times subordinated our fee interest and allowed our property to be pledged as collateral for third-party loans. We have no contractual obligation to make payments on these third-party loans, but our property could be subject to loss in the case of default by the lessee.

Regulations Affecting Real Property. We are subject to a number of laws and regulations affecting our use of, and purchase and sale of, real property. Among these are California s seismic standards, the Americans with Disabilities Act (ADA), and various environmental laws and regulations.

The State of California has established standards intended to ensure that all hospitals in the state withstand earthquakes and other seismic activity without collapsing or posing the threat of significant loss of life. In general, we are required to meet these standards by December 31, 2012, subject to a two-year extension for hospital projects that are underway in advance of that date. In November 2007, the California Building Standards Commission adopted regulations permitting the use of a new computerized evaluation tool for determining how at risk hospital buildings are of collapse in an earthquake, and the use of this new tool has resulted in fewer hospitals requiring retrofitting by the 2012 deadline. We currently estimate spending a total of approximately $80 million to comply with the requirements under California s seismic regulations, of which approximately $24 million was spent prior to January 1, 2010. Our current estimated seismic costs are considerably lower than certain previous estimates because a number of our hospitals have been evaluated as having reduced risk using the new evaluation tool. There may be further reductions to our estimated seismic costs as the State of California has recently enacted new regulations relating to the seismic evaluation tool and the new state building code; we are currently evaluating these new regulations to determine what impact they will have on our cost estimate. Our total estimated seismic expenditure amount has not been adjusted for future inflation. In addition to safety standards, over time, hospitals must also meet performance standards meant to ensure that they are generally capable of providing medical services to the public after an earthquake or other disaster. Ultimately, all general acute care hospitals in California must meet seismic performance standards by 2030 to remain open. To date, we have conducted engineering studies and developed compliance plans for all of our California facilities. At this time, all of our general acute care hospitals in California are in compliance with all current seismic requirements.

The Americans with Disabilities Act generally requires that public accommodations, including hospitals and other health care facilities, be made accessible to disabled persons. Certain of our facilities are subject to a negotiated consent decree involving disability access as a result of a class action lawsuit. In accordance with the terms of the consent decree, our facilities have agreed to implement disability access improvements, but have not admitted that they have engaged in any wrongful action or inaction. To date, we have spent approximately $19 million on corrective work at our facilities, and we expect to spend a total of approximately $111 million on such improvements over the next six years.

Our properties are also subject to various federal, state and local environmental laws, rules and regulations, including with respect to asbestos abatement and the treatment of underground storage tanks, among other matters. We believe it is unlikely that the cost of complying with such laws, rules and regulations will have a material effect on our future capital expenditures, results of operations or competitive position.

Table of Contents

MEDICAL STAFF AND EMPLOYEES

General. Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by the hospital s local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of hospitals not owned by us. Members of our medical staffs are free to terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. Although we operate some physician practices and, where permitted by law, employ some physicians, the overwhelming majority of the physicians who practice at our hospitals are not our employees. However, nurses, therapists, lab technicians, facility maintenance workers and the administrative staffs of hospitals normally are our employees. We are subject to federal minimum wage and hour laws and various state labor laws, and maintain a number of different employee benefit plans.

Our operations depend on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no contractual relationship with us. It is essential to our ongoing business that we attract and retain an appropriate number of quality physicians in all specialties on our medical staffs. Although we had a net overall gain in physicians added to our medical staffs in each of the last three years, in some of our markets, physician recruitment and retention are still affected by a shortage of physicians in certain sought-after specialties and the difficulties that physicians experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Other issues facing physicians, such as proposed decreases in Medicare payments, are forcing them to consider alternatives, including relocating their practices or retiring sooner than expected.

We continue to take steps to successfully attract and retain key employees, qualified physicians and other health care professionals. One of our initiatives is our *Physician Relationship Program*, which is centered on understanding the needs of physicians who admit patients both to our hospitals and to our competitors hospitals and responding to those needs with changes and improvements in our hospitals and operations. In general, the loss of some or all of our key employees or the inability to attract or retain sufficient numbers of qualified physicians and other health care professionals could have a material adverse effect on patient volumes and, thereby, our business, financial condition, results of operations or cash flows.

At December 31, 2009, the approximate number of our employees (of which approximately 25% were part-time employees) was as follows:

General hospitals and related health care facilities(1)	56,948
Administrative offices	665
Total	57,613

(1) Includes employees whose employment related to the operations of our general hospitals, critical access facility, long-term acute care hospital, outpatient surgery centers, diagnostic imaging centers, occupational and rural health care clinics, physician practices, in-house collection agency and other health care operations in both continuing and discontinued operations.

At December 31, 2009, the largest concentrations of our employees (excluding those in our administrative offices, but including those at our general hospitals and related health care facilities in both continuing and discontinued operations) were in those states where we had the largest concentrations of licensed hospital beds:

	% of employees	% of licensed beds
California	20.7%	17.0.%
Florida	19.8%	25.6%
Texas	16.7%	19.3%

Union Activity and Labor Relations. At December 31, 2009, approximately 19% of the employees at our hospitals and related health care facilities in both continuing and discontinued operations were represented by labor unions. Labor relations at our facilities generally have been satisfactory. We, and the hospital industry in general, are continuing to see an increase in the amount of union activity across the country. We expect this trend to be even more pronounced in 2010, as we renegotiate our existing labor contracts, all of which are scheduled to expire in the next 14 months. As union activity increases, our operating expenses may increase more rapidly than our net operating revenues.

In addition, legislation has been introduced in Congress that could significantly change both union organizing and bargaining over initial labor contracts in a way that is likely to increase union membership, at least in the short term. We are unable to predict what action Congress or the President might take with respect to this or any other labor-related legislation or the impact such legislation might ultimately have on our relations with employees and unions.

We currently have labor contracts and collective bargaining agreements with the California Nurses Association (CNA), the Service Employees International Union (SEIU), the United Nurses Associations of California (UNAC) and the American Federation of State, County and Municipal Employees that cover registered nurses, service and maintenance workers, and other employees at 10 of our general hospitals in California, three of our general hospitals in Florida and one of our general hospitals in Philadelphia. All of these union agreements set stable and competitive wage increases within our budgeted expectations through various dates in 2010 and early 2011. In January 2010, we commenced the process of renegotiating these contracts, beginning with our collective bargaining agreements with UNAC at two of our hospitals in California.

Table of Contents

We also have separate peace accords with both the CNA and the SEIU that provide each union with limited access to attempt to organize certain of our employees and establish specific guidelines for the parties to follow with respect to organizing activities. Both peace accords expire in December 2011. Such agreements have become more common as employers attempt to balance the disruption caused by traditional union organizing with the rights of employees to determine for themselves whether to seek union representation.

The CNA and the SEIU have engaged in union organizing activities at several of our hospitals in Houston, Memphis and Philadelphia pursuant to the terms of the peace accords. Registered nurses at two of these facilities have participated in elections concerning CNA representation, but to date union organizing has been successful at only Cypress Fairbanks Medical Center (CyFair). After extended collective bargaining negotiations over an initial contract for CyFair, the CNA triggered an agreed-to interest arbitration process, which began in June 2009, that provides for a neutral third party to mediate unresolved contract terms. If the mediation is unsuccessful, those unresolved terms will be decided by binding arbitration.

We are also defending various allegations that we are in violation of federal labor laws or the terms of our collective bargaining agreements and peace accords, and we expect to continue to be subject to such claims from time to time in the normal course of business.

Shortage of Experienced Nurses and Mandatory Nurse-Staffing Ratios. In addition to union activity, factors that adversely affect our labor costs include the nationwide shortage of experienced nurses and the enactment of state laws regarding nurse-staffing ratios. Like others in the health care industry, we continue to experience a shortage of experienced nurses in certain key specialties and geographic areas. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. We continually monitor our nurse-staffing ratios in California in an effort to achieve full compliance with the state-mandated nurse-staffing ratios there. Nurse-staffing ratio legislation has been proposed in, but not yet enacted by, Congress and other states besides California in which we operate hospitals, including Florida and Pennsylvania. In 2009, Texas passed the Hospital Safe Staffing Law, which mandates the creation of nurse staffing committees at Texas hospitals and outlines each hospital s responsibility to adopt, implement and enforce an official nurse staffing plan, but does not mandate staffing ratios. Also in 2009, the Missouri Department of Health and Senior Services published amendments to the state s hospital nursing services regulations, which became effective on June 30, 2009, that are similar to the new Texas requirements with respect to nurse staffing.

We cannot predict the degree to which we will be affected by the future availability or cost of nursing personnel, but we expect to continue to experience salary, wage and benefit pressures created by the shortage of experienced nurses throughout the country and state-mandated nurse-staffing ratios, particularly in California. In response, we have increased our efforts to recruit and retain experienced nurses and also to address workforce development with local schools of nursing. We expect that 30 of our hospitals will participate in the Versant™ RN Residency Program in 2010 by providing an 18- to 22-week residency program for new nursing school graduates to help ease the transition from student to professional practicing nurse, give nurses evidence-based experience and skills needed to increase their competency and confidence, reduce first-year nurse turnover and decrease the use of contract labor.

COMPETITION

In general, competition among health care providers occurs primarily at the local level. A hospital s position within the geographic area in which it operates is affected by a number of competitive factors, including, but not limited to (1) the scope, breadth and quality of services a hospital offers to its patients and physicians, (2) the number, quality and specialties of the physicians who admit and refer patients to the hospital, (3) nurses and other health care professionals employed by the hospital or on the hospital s staff, (4) the hospital s reputation, (5) its managed care contracting relationships, (6) its location, (7) the location and number of competitive facilities and other health care alternatives, (8) the physical condition of its buildings and improvements, (9) the quality, age and state-of-the-art of its medical equipment, (10) its parking or proximity to public transportation, (11) the length of time it has been a part of the community, and (12) the charges for its services. In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. We also face increasing competition from physician-owned specialty hospitals and freestanding diagnostic and imaging centers for market share in high margin services and for quality physicians and personnel.

Table of Contents

Overall, our general hospitals and other health care businesses operate in highly competitive environments. Although we have seen some improvements in recent quarters, we have experienced declines in patient volumes over the last several years. We believe these declines can be attributed, in part, to increased competition for physicians and patients. We continue to take steps to address competition and increase patient volumes; however, due to the concentration of our hospitals in California, Florida and Texas, we may not be able to mitigate some factors that contribute to volume declines. Broadly speaking, we attract physicians by striving to equip our hospitals with technologically advanced equipment and quality physical plant, properly maintaining the equipment and physical plant, providing high-quality care to our patients and otherwise creating an environment within which physicians prefer to practice. One of our specific initiatives is our *Physician Relationship Program,* which is centered on understanding the needs of physicians who admit patients both to our hospitals and to our competitors hospitals and responding to those needs with changes and improvements in our hospitals and operations. We have targeted capital spending in order to address specific needs or growth opportunities of our hospitals, which is expected to have a positive impact on their volumes. We have also sought to include all of our hospitals and an increased number of our affiliated physicians in the affected geographic area or nationally when negotiating new managed care contracts, which should result in additional volumes at facilities that were not previously a part of such managed care networks. In addition, we have completed clinical service line market demand analyses and profitability assessments to determine which services are highly valued that can be emphasized and marketed to improve our operating results. This *Targeted Growth Initiative* has resulted in some reductions in unprofitable service lines in several locations, which have had a slightly negative impact on our volumes. However, the elimination of these unprofitable service lines will allow us to focus more resources on services that are in higher demand and are more profitable.

Our *Commitment to Quality* initiative is further helping position us to competitively meet the volume challenge. We continue to work with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care. As a result of these efforts, our hospitals have improved substantially in quality metrics reported by the government and have been recognized by several managed care companies for their quality of care. In our continuing efforts to improve our clinical outcomes and drive down our costs of care, we launched our *Medicare Performance Initiative* in 2009. This initiative is focused on the identification and reduction of costs associated with variations in physician and hospital practices. The project includes the dissemination of best practices based on evidence-based medicine, which we expect will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. We believe that quality of care improvements will continue to have the effect of increasing physician and patient satisfaction, potentially improving our volumes.

Further, each hospital has a local governing board, consisting primarily of community members and physicians, that develops short-term and long-term plans for the hospital to foster a desirable medical environment for physicians. Each local governing board also reviews and approves, as appropriate, actions of the medical staff, including staff appointments, credentialing, peer review and quality assurance. While physicians may terminate their association with our hospitals at any time, we believe that by striving to maintain and improve the quality of care at our hospitals and by maintaining ethical and professional standards, we will attract and retain qualified physicians with a variety of specialties.

HEALTH CARE REGULATION AND LICENSING

CERTAIN BACKGROUND INFORMATION

Health care, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. Changes in the Medicare and Medicaid programs and other government health care programs, hospital cost-containment initiatives by public and private payers, proposals to limit payments and health care spending, and industry-wide competitive factors greatly impact the health care industry. The industry is also subject to extensive federal, state and local regulation relating to licensure, conduct of operations, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the health care industry are extremely complex, and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition, results of operations or cash flows could be materially adversely affected. In addition, we are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Table of Contents

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the health care industry. Under the authority of the Inspector General Act of 1978, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) on an annual basis conducts a comprehensive work-planning process to identify the areas most worthy of attention in the coming year. In recent years, the OIG has allocated approximately 80% of its resources to reviews and investigations of the Medicare and Medicaid programs and 20% to HHS public health and human services programs. In its fiscal year 2010 Work Plan, the OIG set forth detailed information about, among other things, its ongoing and planned work examining the integrity of Medicare and Medicaid payments and services, including payments made to and services provided by hospitals. An online version of the 2010 Work Plan is available at http://oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf. We believe that we, and the health care industry in general, will continue to be subject to increased government scrutiny and investigations, which could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Health care providers are also subject to qui tam lawsuits under the federal False Claims Act. Qui tam or whistleblower actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies. Federal and state false claims laws allow private individuals to bring actions on behalf of the government, alleging that a hospital or health care provider has defrauded a federal or state government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. Although companies in the health care industry in general, and us in particular, have been and may continue to be subject to qui tam actions, we are unable to predict the future impact of such actions on our business, financial condition, results of operations or cash flows.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the Anti-kickback Statute) prohibit certain business practices and relationships that might affect the provision and cost of health care services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Sanctions for violating the Anti-kickback Statute include criminal and civil penalties, as well as fines and possible exclusion from government programs, such as Medicare and Medicaid. Many states have statutes similar to the federal Anti-kickback Statute, except that the state statutes usually apply to referrals for services reimbursed by all third-party payers, not just federal programs. In addition, it is a violation of the federal Civil Monetary Penalties Law to offer or transfer anything of value to Medicare or Medicaid beneficiaries that is likely to influence their decision to obtain covered goods or services from one provider or service over another.

The federal government has also issued regulations that describe some of the conduct and business relationships that are permissible under the Anti-kickback Statute. These regulations are often referred to as the Safe Harbor regulations. The fact that certain conduct or a given business arrangement does not meet a Safe Harbor does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. Rather, such conduct and business arrangements may be subject to increased scrutiny by government enforcement authorities and should be reviewed on a case-by-case basis.

In addition to addressing other matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program.

Section 1877 of the Social Security Act (commonly referred to as the Stark law) generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined designated health services, such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services. The exceptions to the referral prohibition cover a broad range of common financial relationships. These statutory, and the subsequent regulatory, exceptions are available to protect certain permitted employment relationships, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for sham arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. Many states have adopted or are considering similar self-referral statutes, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by these amendments and similar state enactments.

9

Table of Contents

In accordance with our compliance program and our corporate integrity agreement with the federal government, which are described in detail under Compliance Program below, we have policies and procedures in place concerning compliance with the Anti-kickback Statute and the Stark law, among others. In addition, our compliance, law and audit services departments systematically review a substantial number of our arrangements with referral sources to determine the extent to which they comply with our policies and procedures and with the Anti-kickback Statute, the Stark law and similar state statutes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

To receive reimbursement from CMS for electronic claims, health care providers must use HIPAA s electronic data transmission (transaction and code set) standards when transmitting certain health care information electronically. Our electronic data transmissions are compliant with current standards.

All covered entities, including those we operate, are also required to comply with the privacy and security requirements of HIPAA. We are in material compliance with the privacy and security regulations, and we will continue to update training and procedures to address any compliance issues that develop. Further, all covered entities, including those we operate, have been assigned unique 10-digit numeric identifiers and otherwise currently comply with the National Provider Identifier requirements of HIPAA.

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

HEALTH CARE FACILITY LICENSING REQUIREMENTS

In order to maintain their operating licenses, health care facilities must comply with strict governmental standards concerning medical care, equipment and cleanliness. Various licenses and permits also are required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Our health care facilities hold all required governmental approvals, licenses and permits material to the operation of their business.

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

10

Table of Contents

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

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, expansion and closure of health care facilities, including findings of need for additional or expanded health care facilities or services. Certificates of need, which are issued by governmental agencies with jurisdiction over health care facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. As of December 31, 2009, we operated hospitals in eight states that require a form of state approval under certificate of need programs applicable to those hospitals. We are unable to predict whether we will be required or able to obtain any additional certificates of need in any jurisdiction where they are required, or if any jurisdiction will eliminate or alter its certificate of need requirements in a manner that will increase competition and, thereby, affect our competitive position.

ENVIRONMENTAL MATTERS

Our health care operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with laws and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather or climate change events affecting our facilities in coastal regions. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws and regulations, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows.

Consistent with our commitment to meet the highest standards of corporate responsibility, we have formed a corporate committee to regularly evaluate our environmental policies and to share best practices among our hospitals by identifying opportunities to reduce waste, use safer chemicals and consume less energy while at the same time managing costs prudently. These efforts, among other things, have resulted in the substantial elimination of the use of mercury at our health care facilities and the adoption of corporate-wide recycling and other programs. We also seek to implement these objectives through our procurement practices by contracting with health care product suppliers and other organizations that endorse environmental and safety goals consistent with our corporate philosophy.

COMPLIANCE PROGRAM

General. We maintain a multi-faceted corporate and hospital-based compliance program that is designed to assist our corporate and hospital staff to meet or exceed applicable standards established by federal and state laws and regulations and industry practice. We established an independent compliance department in 2003 to manage compliance-related functions previously managed by our law department. To ensure the independence of the compliance department, the following measures were implemented:

- the compliance department has its own operating budget;
- the compliance department has the authority to hire outside counsel, access any Tenet document and interview any of our personnel; and
- our chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

11

Table of Contents

In May 2008, the quality, compliance and ethics committee of our board of directors approved an updated ethics and compliance program charter that furthers our goal of fostering and maintaining the highest ethical standards, and valuing our compliance with all state and federal laws and regulations as a foundation of our corporate philosophy. The primary focus of the program is compliance with the requirements of the Medicare and Medicaid programs and other government healthcare programs. Pursuant to the terms of the charter, the compliance department is responsible for the following activities: (1) drafting company policies and procedures related to ethics and compliance issues; (2) developing and providing compliance-related education and training to all of our employees and, as appropriate, directors, contractors, agents and staff physicians; (3) creating and disseminating our *Standards of Conduct*; (4) monitoring, responding to and resolving all ethics and compliance-related issues; (5) ensuring that we take appropriate corrective and disciplinary action when noncompliant or improper conduct is identified; and (6) measuring compliance with our policies and legal and regulatory requirements related to federal health care programs and our corporate integrity agreement described below.

Each of our hospitals has a compliance officer on site. These hospital-based compliance officers report to regional compliance directors who report directly to our chief compliance officer.

Corporate Integrity Agreement. In June 2006, we entered into a broad civil settlement agreement with the U.S. Department of Justice (DOJ) and other federal agencies that concluded several previously disclosed governmental investigations, including inquiries into our receipt of certain Medicare outlier payments before 2003, physician financial arrangements and Medicare coding issues. In accordance with the terms of the settlement, we entered into a five-year corporate integrity agreement (CIA) in September 2006 with the OIG. The CIA establishes annual training requirements and compliance reviews by independent review organizations in specific areas. In particular, the CIA requires, among other things, that we:

- maintain our existing company-wide quality initiatives in the areas of evidence-based medicine, standards of clinical excellence and quality measurements;
- maintain our existing company-wide compliance program and code of conduct;
- formalize in writing our policies and procedures in the areas of billing and reimbursement, compliance with the Anti-kickback Statute and the Stark law, and clinical quality, almost all of which were already in place when we entered into the CIA and the remainder of which were put into place by January 2007;
- provide a variety of general and specialized compliance training to our employees, contractors and physicians we employ or who serve as medical directors and/or serve on our hospitals governing boards; and
- engage independent outside entities to provide reviews of compliance and effectiveness in five areas Medicare outlier payments, diagnosis-related group claims, unallowable costs, physician financial arrangements and clinical quality systems.

Further, the CIA requires us to maintain or establish performance standards and incentives that link compensation and incentive awards directly to clinical quality measures and compliance program effectiveness measures. The CIA also establishes a number of specific requirements for the quality, compliance and ethics committee of our board of directors. Notably, the committee must (1) retain an independent compliance expert, and (2) assess our compliance program, including arranging for the performance of a review of the effectiveness of the program. Based on this work, the committee must then adopt a resolution for each reporting period of the CIA regarding its conclusions as to whether we have implemented an effective compliance program.

The CIA has the effect of increasing the amount of information we provide the federal government regarding our health care practices and our compliance with federal regulations. The reports we provide could result in greater scrutiny by regulatory authorities. In addition, any determination that we have breached our CIA or violated applicable health care laws or regulations could subject us to repayment obligations, civil and monetary penalties, exclusion from participation in the Medicare, Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. We have taken, and continue to take, all necessary steps to promote compliance with the terms of the CIA.

ETHICS PROGRAM

We maintain a values-based ethics program that is designed to monitor and raise awareness of ethical issues among employees and to stress the importance of understanding and complying with our *Standards of Conduct*.

All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Standards of Conduct* to ensure that our business is conducted in a legal and ethical manner. The members of our board of directors and many of our contractors are also required to abide by our *Standards of Conduct*. The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable laws and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

Table of Contents

As part of the program, we provide annual ethics and compliance training sessions to every employee, as well as our board of directors and certain physicians and contractors. All employees are required to report incidents that they believe in good faith may be in violation of the *Standards of Conduct*, and are encouraged to contact our 24-hour toll-free Ethics Action Line when they have questions about the standards or any ethics concerns. Incidents of alleged financial improprieties reported to the Ethics Action Line or the compliance department are communicated to the audit committee of our board of directors. All reports to the Ethics Action Line are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. In cases reported to the Ethics Action Line that involve a possible violation of the law or regulatory policies and procedures, the matter is referred to the compliance department for investigation. Retaliation against employees in connection with reporting ethical concerns is considered a serious violation of our *Standards of Conduct*, and, if it occurs, it will result in discipline, up to and including termination of employment.

The full text of our *Standards of Conduct,* and a number of our ethics and compliance policies and procedures, are published on our website, at www.tenethealth.com, under the Ethics and Compliance caption in the About section. A copy of our *Standards of Conduct* is also available upon written request to our corporate secretary.

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 periods April 1, 2009 through March 31, 2010 and April 1, 2008 through March 31, 2009, we have coverage totaling $600 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million each for floods and earthquakes and a per-occurrence sub-limit of $100 million for windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and windstorms, the total $600 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for floods, California earthquakes and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Insurance. As is typical in the health care industry, we are subject to claims and lawsuits in the ordinary course of business. The health care industry has seen significant increases in the cost of professional liability insurance due to increased litigation. In response, we formed and maintain captive insurance companies to self-insure a substantial portion of our professional and general liability risk. Claims in excess of our self-insurance retentions are insured with commercial insurance companies.

For the policy period June 1, 2009 through May 31, 2010, our hospitals generally have a self-insurance retention of $5 million per occurrence for all claims incurred. Our captive insurance company, The Healthcare Insurance Corporation (THINC), retains $10 million per occurrence above our hospitals $5 million self-insurance retention level. The next $10 million of claims in excess of these aggregate self-insurance retentions of $15 million per occurrence are 65% reinsured by THINC with independent reinsurance companies, with THINC retaining 35% or a maximum of $3.5 million. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies with major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $175 million, with Tenet retaining 20% of the initial $50 million layer in excess of $25 million per claim or a maximum of $10 million.

For the policy period June 1, 2008 through May 31, 2009, our hospitals generally have a self-insurance retention of $5 million per occurrence for all claims incurred. THINC retains $10 million per occurrence above our hospitals $5 million self-insurance retention level. Claims in excess of these aggregate self-insurance retentions of $15 million per occurrence are substantially reinsured up to $25 million, with THINC retaining 30% of the next $10 million for each claim that exceeds $15 million or a maximum of $3 million. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies with major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $275 million.

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

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

13

Table of Contents

EXECUTIVE OFFICERS

The names, positions and ages of our executive officers, as of February 12, 2010, are:

	Position	Age
Trevor Fetter	President and Chief Executive Officer	50
Stephen L. Newman, M.D.	Chief Operating Officer	59
Biggs C. Porter	Chief Financial Officer	56
Gary Ruff	Senior Vice President, General Counsel and Secretary	50
Cathy Fraser	Senior Vice President, Human Resources	45

Mr. Fetter was named Tenet s president in November 2002 and was appointed chief executive officer and a director in September 2003. From March 2000 to November 2002, Mr. Fetter was chairman and chief executive officer of Broadlane, Inc. From October 1995 to February 2000, he served in several senior management positions at Tenet, including chief financial officer. Mr. Fetter began his career with Merrill Lynch Capital Markets, where he concentrated on corporate finance and advisory services for the entertainment and health care industries. In 1988, he joined Metro-Goldwyn-Mayer, Inc., where he had a broad range of corporate and operating responsibilities, rising to executive vice president and chief financial officer. Mr. Fetter holds an M.B.A. from Harvard Business School and a bachelor s degree in economics from Stanford University. Mr. Fetter is a member of the board of directors of The Hartford Financial Services Group, Inc. He will complete his one-year term as the chairman of the board of directors of the Federation of American Hospitals on March 1, 2010, but will remain a director.

Dr. Newman was appointed chief operating officer in January 2007. From March 2003 through December 2006, he served as chief executive officer of our California region. He joined Tenet in February 1999 as vice president, operations, of our former three-state Gulf States region and, in June 2000, he was promoted to senior vice president, operations, of that region. From April 1997 until he came to Tenet, Dr. Newman served in various executive positions at Columbia/HCA Inc., most recently as president of that company s three-hospital Louisville Healthcare Network. From August 1990 to March 1997, he was senior vice president and chief medical officer of Touro Infirmary in New Orleans. Prior to 1990, Dr. Newman was both associate professor of pediatrics and medicine at Wright State University School of Medicine in Dayton, Ohio, and director of gastroenterology and nutrition support at Children s Medical Center, also in Dayton. Dr. Newman holds a medical degree from the University of Tennessee, an M.B.A. from Tulane University and a bachelor s degree from Rutgers University. He completed his internship, residency and fellowship at Emory University School of Medicine. He also completed the Advanced Management Program at the University of Pennsylvania s Wharton School of Business. Dr. Newman is a member of the board of directors of the Federation of American Hospitals.

Mr. Porter joined Tenet as chief financial officer in June 2006. From May 2003 until June 2006, he served as vice president and corporate controller of Raytheon Company. In addition, Mr. Porter served as acting chief financial officer for Raytheon from April 2005 to March 2006. From December 2000 to May 2003, he was senior vice president and corporate controller of TXU Corp. and, from August 1994 to December 2000, he was chief financial officer of Northrop Grumman Corporation s integrated systems sector and its commercial aircraft division. Mr. Porter has also served as vice president, controller and assistant treasurer of Vought Aircraft Company, corporate manager of external financial reporting for LTV Corporation, and audit principal at Arthur Young & Co. He is a certified public accountant. Mr. Porter holds a master s degree in accounting from the University of Texas/Austin and a bachelor s degree in accounting from Duke University.

Mr. Ruff was appointed senior vice president and general counsel in July 2008. From 2003 until his promotion, he served as vice president and assistant general counsel for hospital operations. In addition, Mr. Ruff acted as the company s interim general counsel from March 2008 to July 2008. Mr. Ruff joined Tenet in 1992 as associate counsel of the company s former Gulf States region, which included 12 hospitals. Before joining Tenet, he was a tax manager for Deloitte & Touche LLP. Mr. Ruff received his master s degree in management from Northwestern University s Kellogg School of Management, his master of laws degree in taxation from Georgetown University, his J.D. from Pepperdine University and his bachelor s degree in accounting from Gonzaga University.

Ms. Fraser joined Tenet as senior vice president, human resources, in September 2006. From June 2000 to September 2006, she served as a management consultant with McKinsey & Co. Inc., the international consulting firm. In that role, Ms. Fraser counseled senior executives at a number of large companies on organizational design, talent management and retention strategies, recruiting and related human resources topics. Prior to her work with McKinsey, Ms. Fraser served as a vice president of Sabre Holdings Inc., a major provider of travel product distribution and technology solutions for the travel industry, from 1994 to 2000. She has also worked for American Airlines and General Motors Acceptance Corp. Ms. Fraser holds an M.B.A. from the University of Michigan, and a bachelor s degree in business administration from the University of Washington in Seattle. She is a board member of Workforce Solutions of Greater Dallas and the JKU Foundation, a family non-profit foundation.

14

Table of Contents

COMPANY INFORMATION

We file annual, quarterly and current reports, proxy statements and other documents with the Securities and Exchange Commission under the Securities Exchange Act of 1934 (the Exchange Act). Our reports, proxy statements and other documents filed electronically with the SEC are available at the website maintained by the SEC at www.sec.gov.

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

FORWARD-LOOKING STATEMENTS

The information in this report includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act. 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 belief, 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 health care 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 Item 1A of this report and the following:

Our ability to identify and execute on measures designed to save or control costs or streamline operations;

The availability and terms of debt and equity financing sources to fund the requirements of our business;

Changes in our business strategies or development plans;

The impact of natural disasters, including our ability to operate facilities affected by such disasters;

The ultimate resolution of claims, lawsuits and investigations;

Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, health care services;

Various factors that may increase supply costs;

The soundness of our investments in marketable securities and other instruments;

The creditworthiness of counterparties to our business transactions;

Adverse fluctuations in interest rates and other risks related to interest rate swaps or any other hedging activities we undertake;

National, regional and local economic and business conditions;

Demographic changes; and

Other factors and risk factors referenced in this report and our other public filings.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in this report. Should one or more of the risks and uncertainties described above, in Item 1A, Risk Factors, below or elsewhere in this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statements. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

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

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties many of which are beyond our control that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in the following risks were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected. Additional risks and uncertainties not presently known, or that we currently deem immaterial, may also negatively affect our business and operations. In either case, the trading price of our common stock could decline and shareholders could lose all or part of their investment.

Table of Contents

If we are unable to enter into managed care provider arrangements on acceptable terms, or if we have difficulty collecting from managed care payers, our results of operations could be adversely affected.

We currently have thousands of managed care contracts with various health maintenance organizations and preferred provider organizations. The amount of our managed care net patient revenues from our continuing general hospitals during the year ended December 31, 2009 was $4.9 billion, which represented approximately 56.1% of our total net patient revenues from continuing general hospitals. In addition, approximately 62% of our managed care net patient revenues for the year ended December 31, 2009 was derived from our top ten managed care payers. Furthermore, in the year ended December 31, 2009, our commercial managed care net inpatient revenue per admission from our continuing acute care hospitals was approximately 58% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. At December 31, 2009, approximately 57% of our net accounts receivable related to continuing operations were due from managed care payers.

It would harm our business if we were unable to enter into managed care provider arrangements on acceptable terms. Any material reductions in the payments that we receive for our services, coupled with any difficulties in collecting receivables from managed care payers, could have a material adverse effect on our financial condition, results of operations or cash flows.

Changes in the Medicare and Medicaid programs or other government health care programs could have an adverse effect on our business.

For the year ended December 31, 2009, approximately 25.1% of our same-hospital net patient revenues were received from the Medicare program, and approximately 8.1% of our same-hospital net patient revenues were received from various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities.

Several states in which we operate have recently faced budgetary challenges that resulted in reduced Medicaid funding levels to hospitals and other providers. Most states began a new fiscal year on July 1, and although most addressed projected shortfalls in their final budgets, some states may face mid-year budget gaps and many are already projecting shortfalls for state fiscal year 2011, which could result in additional reductions to Medicaid payments, coverage and eligibility or additional taxes on hospitals.

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

Our business continues to be adversely affected by a high volume of uninsured and underinsured patients, as well as declines in commercial managed care patients.

Like other organizations in the health care industry, we continue to provide services to a high volume of uninsured patients and more patients than in prior years with an increased burden of co-payments and deductibles as a result of changes in their health care plans. As a result, we continue to experience a high level of uncollectible accounts, and, unless our business mix shifts toward a greater number of insured patients or the trend of higher co-payments and deductibles reverses, we anticipate this high level of uncollectible accounts to continue or increase.

At the same time, we continue to experience declines in our commercial managed care volumes, which in the aggregate generate substantially higher yields than Medicare and Medicaid volumes. In the year ended December 31, 2009, same-hospital commercial managed care admissions declined 4.7% and same-hospital commercial managed care outpatient visits declined 1.2%, in each case compared to the year ended December 31, 2008. The declines in our commercial managed care volumes are due, in part, to the related effects of higher unemployment and reductions in commercial managed care enrollment. Going forward, our commercial managed care volumes may also be adversely impacted by the expiration of federal subsidies for those unemployed individuals and their family members who have been receiving subsidized continued health insurance coverage under their former employers health plans. Without these subsidies, health insurance coverage could become unaffordable for these people, which could result in lower commercial managed care volumes especially with respect to elective procedures at our hospitals.

16

Table of Contents

We operate in a highly competitive industry, and competition is one reason for declines we may experience in patient volumes.

A number of factors affect patient volumes and, thereby, our results of operations at our hospitals and related health care facilities, including the influence of local health care competitors. Generally, other hospitals in the local communities we serve provide services similar to those offered by our hospitals. Some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations. These tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. We also face increasing competition from physician-owned specialty hospitals and freestanding surgery, diagnostic and imaging centers for market share in high margin services and for quality physicians and personnel. If competing health care providers are better able to attract more patients, recruit and retain physicians, expand services or obtain favorable managed care contracts at their facilities, our patient volume levels may suffer.

Our business and financial condition could be harmed if we are not able to attract and retain employees, physicians and other health care professionals, and our labor costs continue to be adversely affected by union activity and the shortage of experienced nurses.

Our operations depend on the efforts, abilities and experience of our employees and the physicians on the medical staffs of our hospitals, most of whom have no contractual relationship with us. It is essential to our ongoing business that we attract and retain skilled employees and an appropriate number of quality physicians and other health care professionals in all specialties on our medical staffs. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain sought-after specialties and the difficulties that physicians experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Other issues facing physicians, such as proposed decreases in Medicare payments, are forcing them to consider alternatives, including relocating their practices or retiring sooner than expected. In general, the loss of some or all of our key employees or the inability to attract or retain sufficient numbers of qualified physicians and other health care professionals could have a material adverse effect on patient volumes and, thereby, our business, financial condition, results of operations or cash flows.

Factors that adversely affect our labor costs include union activity, the nationwide shortage of experienced nurses and the enactment of state laws regarding nurse-staffing ratios. At December 31, 2009, approximately 19% of the employees at our hospitals and related health care facilities in both continuing and discontinued operations were represented by labor unions, and we (and the hospital industry in general) are continuing to see an increase in the amount of union activity across the country. We expect this trend to be even more pronounced in 2010, as we renegotiate our existing labor contracts, all of which are scheduled to expire in the next 14 months. Furthermore, like others in the health care industry, we continue to experience a shortage of experienced nurses in certain key specialties and geographic areas. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. We cannot predict the degree to which we will be affected by future union activity or the future availability or cost of nursing personnel, but we expect to continue to experience salary, wage and benefit pressures.

Our licensed hospital beds are heavily concentrated in certain market areas in Florida, Texas and California, which makes us sensitive to economic, regulatory, environmental and other developments in those areas.

As of December 31, 2009, the largest concentrations of licensed beds in our general hospitals were in Florida (25.6%), Texas (19.3%) and California (17.0%). These concentrations increase the risk that, should any adverse economic, regulatory, environmental or other developments occur in these areas, our business, financial condition, results of operations or cash flows could be materially adversely affected.

Specifically, a natural disaster or other catastrophic event could affect us more significantly than other companies with less geographic concentration. In the recent past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida and Texas, as well as in Louisiana, and the patient populations in those states. Our California operations could be adversely affected by a major earthquake or wildfires in that state. Moreover, we currently expect to spend a total of approximately $80 million (unadjusted for inflation) to comply with the requirements of California s seismic regulations for hospitals, of which approximately $24 million was spent prior to January 1, 2010.

Table of Contents

Our business and financial results could be harmed by violations of existing regulations or compliance with new or changed regulations.

Our business is subject to extensive federal, state and local regulation relating to, among other things, licensure, conduct of operations, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the health care industry are extremely complex, and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. If a determination is made that we were in material violation of such laws, rules or regulations, we could be subject to penalties or liabilities or required to make significant changes to our operations. In addition, health care, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We are also required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

We cannot predict the effect that health care reform, if any, and other changes in government programs may have on our business, financial condition, results of operations or cash flows.

National health care reform is a focus at the federal level, and Congress is currently considering a number of proposals that may significantly impact the health care industry. Among other things, these proposals intend to decrease the number of uninsured legal U.S. residents and reduce health care costs. Various mechanisms to fund health care reform legislation are being considered, including proposals that could reduce hospital reimbursement or otherwise adversely affect our revenues, and various mechanisms to control health care costs are being considered, including proposals that could impose new information technology requirements on our hospitals or otherwise increase our operating costs. Several states are also considering health care reform measures. We cannot predict what form health care reform will take, or if significant health care reform in the near term will take place at all. While federal or state health care reform could adversely affect our business, financial condition, results of operations or cash flows, a decision by Congress not to enact significant health care reform in the near term could also have a negative impact on investor sentiment about companies in the health care industry and, therefore, adversely affect the trading price of our common stock.

The focus on health care reform may also increase the likelihood of material changes to existing government health care programs. A significant portion of both our patient volumes and, as a result, our revenues is derived from government health care programs, principally Medicare and Medicaid. In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under these government programs. Possible future changes in Medicare, Medicaid and other health care programs may reduce reimbursements to health care providers and insurers and may also increase our operating costs, which could have an adverse effect on our business, financial condition, results of operations or cash flows.

Our operations have not been profitable for most of the last several years, and, if industry trends or general economic conditions worsen, our business operations and financial results may continue to be adversely affected.

We reported losses from continuing operations for the years ended December 31, 2003 through 2007, a period during which we restructured our business to focus on a smaller group of general hospitals. Although our results of operations have recently improved, we continue to be impacted by a number of industry-wide and company-specific challenges, including declines in patient volumes over the last several years and high bad debt levels. Furthermore, we believe factors associated with the current economic downturn including higher levels of unemployment, reductions in commercial managed care enrollment, tightened credit markets, and instability in the banking and financial institution industries have had some impact on our volumes and have affected our ability to collect outstanding receivables. If industry trends or general economic conditions worsen, we may not be able to achieve or sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Trends affecting our actual or anticipated results may lead to charges that would adversely affect our results of operations.

As a result of factors that have affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. Our impairment tests presume stable, improving or, in some cases, declining results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital s most recent projections. If these projection*s* are not met, or if in the future negative trends occur that impact our future outlook, further impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges. Future restructuring of our operating structure that changes our goodwill reporting units could also result in further impairments of our goodwill. Any such charges could adversely affect our results of operations.

Table of Contents

The recent worldwide financial and credit crisis could have a material adverse effect on our business, financial condition and results of operations.

The recent worldwide financial and credit crisis has reduced the availability of liquidity and credit to fund the continuation and expansion of many business operations worldwide. This shortage of liquidity and credit, combined with substantial losses in worldwide equity markets, could lead to an extended worldwide economic recession and result in a material adverse effect on our business, financial condition, results of operations or cash flows. Our ability to access the capital markets may be severely restricted at a time when we would like, or need, to access those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions, and our ability to refinance existing debt. The financial and credit crisis also could have an impact on the lenders under our credit facilities, causing them to fail to meet their obligations to us.

Our substantial leverage could have a material adverse effect on our operations.

We are a highly leveraged company. As of December 31, 2009, we had approximately $4.3 billion of total long-term debt, as well as approximately $185 million in letters of credit outstanding under our senior secured revolving credit facility, which is collateralized by patient accounts receivable at our acute care and specialty hospitals. From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time.

Our leverage and debt service obligations could have important consequences to an investor, including the following:

Our credit agreement and the indentures governing our outstanding senior notes contain, and any future debt obligations may contain, covenants that, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. Our credit agreement also requires us to maintain certain financial ratios. The indentures governing our outstanding senior secured notes contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions or consolidate, merge or sell all or substantially all of our or their assets. If we do not comply with these obligations, it may cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately.

We may be more vulnerable in the event of a deterioration in our business, in the health care industry, in the economy generally or if federal or state governments set further limitations on reimbursement under the Medicare or Medicaid programs.

We may have difficulty obtaining additional financing at economically acceptable interest rates and other terms to meet our requirements for working capital, capital expenditures, the payment of judgments or settlements, or general corporate purposes.

We may be required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which could reduce the amount of funds available for our operations or capital expenditures.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Note: The disclosure required under this Item is included in Item 1.

Table of Contents

ITEM 3. LEGAL PROCEEDINGS

Because we provide health care services in a highly regulated industry, we have been and expect to continue to be subject to various lawsuits, claims and regulatory proceedings from time to time. The ultimate resolution of these matters, individually or in the aggregate, whether as a result of litigation or settlement, could have a material adverse effect on our business (both in the near and long term), financial condition, results of operations or cash flows. We are currently a party to a number of legal and regulatory proceedings, including those described below.

GOVERNMENTAL REVIEWS

Pursuant to the five-year corporate integrity agreement we entered into with the Office of Inspector General in September 2006, we notified the OIG in October 2007 that we had completed a preliminary review of admissions to our inpatient rehabilitation unit at South Fulton Medical Center in East Point, Georgia that suggested further review was necessary to determine whether South Fulton had received Medicare overpayments reportable under our CIA. In January 2008, we submitted this matter into the OIG s voluntary self-disclosure protocol. The OIG subsequently accepted our submission. In February 2009, we received a letter from the Department of Justice, which is participating in this matter with the OIG, requesting additional information regarding the basis for our self-disclosure, as well as information related to admissions at our other active and divested inpatient rehabilitation hospitals and units for the period 2000 to the date of the letter. The government has since limited the scope of its review to the period May 2005 through December 31, 2007. In addition, the government asked to examine a limited sample of patient files at two inpatient rehabilitation facilities besides South Fulton Medical Center before it determines if its review should extend to our other inpatient rehabilitation units. That examination has been completed, and we are continuing to work with the DOJ and the OIG regarding their review. We are unable to predict the timing and outcome of this matter at this time.

Separately, in 2009, the DOJ, through the U.S. Attorney s Office in the Western District of New York, and the OIG contacted a number of hospitals, including one Tenet hospital, requesting information regarding their billing practices for kyphoplasty procedures. Kyphoplasty is a surgical procedure used to treat pain and related conditions associated with certain vertebrae injuries. The DOJ and the OIG requested the information in connection with their review of the appropriateness of Medicare patients receiving kyphoplasty procedures on an inpatient basis as opposed to an outpatient basis. To date, the request has been limited to only one of our hospitals. We are fully cooperating with the DOJ and the OIG, and have provided the requested information on a voluntary basis. We are unable to predict the timing and outcome of the investigation, which is still in its preliminary stages at this time. However, based on the total number of inpatient kyphoplasty procedures conducted during the review period at the hospital subject to the information request, we do not believe the outcome of this review will have a material adverse impact on us.

In addition, in February 2009, the fiscal intermediary for our Florida Medical Center began a probe review of the group billing practices of that facility s partial hospitalization program, a psychiatric treatment program that had the capacity to treat 15 patients on an outpatient basis. We also examined the records reviewed by the fiscal intermediary and independently determined that patients had multiple outpatient admissions with lengths of stay longer than expected for this program. As a result of our review of this matter, we closed the program and, pursuant to our CIA, notified the OIG about our findings. We have since engaged an external physician expert to assess the medical necessity and length of stay of the admissions in question. We are working to complete our assessment, but are unable to predict the timing and outcome of this matter at this time.

WAGE AND HOUR ACTIONS

In September 2004, the court granted our petition to coordinate two pending proposed class action lawsuits, *McDonough, et al. v. Tenet Healthcare Corporation* and *Tien, et al. v. Tenet Healthcare Corporation*, in Los Angeles Superior Court. The *McDonough* case was originally filed in June 2003 in San Diego Superior Court, and the *Tien* case was originally filed in May 2004 in Los Angeles Superior Court. Plaintiffs in both cases allege that our hospitals violated certain provisions of the California Labor Code and applicable California Industrial Welfare Commission Wage Orders with respect to meal breaks, rest periods and the payment of one hour s compensation for meal breaks or rest periods not taken. The complaint in the *Tien* case also alleges that we have improperly rounded off time entries on timekeeping records and that our pay stubs do not include all information required by California law. Plaintiffs in both cases are seeking back pay, statutory penalties, interest and attorneys fees.

The plaintiffs in the *McDonough* and *Tien* cases filed motions, which we opposed, to certify these actions on behalf of virtually all nonexempt employees of our California subsidiaries, as separated into four classes (and one subclass) based on the specific claims at issue. The court issued an initial ruling on the plaintiffs motions in June 2008. In that ruling, the court denied the plaintiffs request for class certification on the claim that employees missed rest periods. However, the court granted the plaintiffs request for class certification on the claims that employees pay stubs did not contain all information required by California law and hourly employees did not receive appropriate wages due at the time of their termination. The court also certified a subclass of 12-hour shift employees who received missed meal penalties at a reduced rate, but stated that this subclass should be handled in connection with the *Pagaduan v. Fountain Valley Regional Medical Center* action that was pending in the same court, which case we subsequently settled

Table of Contents

in May 2009. Lastly, the court conditionally certified a class of all current or former hourly employees who were allegedly not provided meal periods, for the purpose of determining certain limited preliminary factual issues. We filed a motion for reconsideration of the court s class certification ruling and, in November 2008, the court issued a reconsidered ruling denying class certification with respect to all of the plaintiffs claims, except the subclass involving 12-hour shift employees. In December 2008, the plaintiffs dismissed the claims of that subclass, which left only the claims of the individual plaintiffs. The plaintiffs subsequently filed a notice of appeal of the court s decision in February 2009. We continue to believe the court s November 2008 ruling was correct and are defending that ruling on appeal.

CLASS ACTION LAWSUITS RESULTING FROM HURRICANE KATRINA

When Hurricane Katrina hit the Gulf Coast region in August 2005, we owned five hospitals and a number of imaging centers in the New Orleans area. As previously reported, three lawsuits were filed as purported class actions in late 2005 by and on behalf of patients, their family members and others who were present and allegedly injured at two of those hospitals Memorial Medical Center and Lindy Boggs Medical Center (each of which we have since divested) during the storm and its aftermath. The plaintiffs allege that the hospitals were negligent in failing to properly prepare for the storm, failing to evacuate patients ahead of the storm, and failing to have a properly configured emergency generator system, among other allegations of general negligence. The plaintiffs are seeking damages in various and unspecified amounts for the alleged wrongful death of some patients, aggravation of pre-existing illnesses or injuries to patients who survived and were successfully evacuated, and the inability of patients and others to evacuate the hospitals for several days under conditions of extreme heat.

In September 2008, class certification was granted in two of the suits *Preston, et al. v. Tenet HealthSystem Memorial Medical Center, Inc., et al.* and *Husband et al. v. Tenet HealthSystem Memorial Medical Center, Inc., et al.* In her order, the judge certified a class of all persons at Memorial between August 29 and September 2, 2005, excluding employees, who sustained injuries or died, as well as family members who themselves sustained injury as a result of such injuries or deaths to any person at Memorial, excluding employees, during that time. Our appeals of the class certification ruling were exhausted in December 2009 when the Supreme Court of Louisiana denied our writ of certiorari. The Civil District Court for the Parish of Orleans will administer the class proceedings. The class certification hearing in the remaining case *Dunn, et al. v. Tenet Mid-City Medical, L.L.C. (formerly d/b/a Lindy Boggs Medical Center), et al.*, which was also filed in the Civil District Court for the Parish of Orleans has been scheduled for late October 2010. We are unable to predict the ultimate resolution of these lawsuits, but we intend to continue to vigorously defend the hospitals in these matters.

INTERNAL REVENUE SERVICE DISPUTES

From time to time, we are engaged in disputes with the Internal Revenue Service regarding our federal tax returns. Refer to Note 14 to our Consolidated Financial Statements for further information.

MEDICAL MALPRACTICE AND OTHER ORDINARY COURSE MATTERS

In addition to the matters described above, our hospitals are subject to investigations, claims and lawsuits in the ordinary course of our business. Most of these matters involve allegations of medical malpractice or other injuries suffered at our hospitals.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

None.

Table of Contents

PART II.

ITEM 5. MARKET FOR REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Common Stock. Our common stock is listed on the New York Stock Exchange under the symbol THC. The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock on the NYSE.

	High	Low
Year Ended December 31, 2009		
First Quarter	$ 1.48	$ 0.78
Second Quarter	4.08	1.04
Third Quarter	6.07	2.57
Fourth Quarter	6.39	4.52
Year Ended December 31, 2008		
First Quarter	$ 5.76	$ 4.04
Second Quarter	6.88	5.16
Third Quarter	6.70	5.19
Fourth Quarter	5.43	0.99

On February 12, 2010, the last reported sales price of our common stock on the NYSE composite tape was $5.21 per share. As of that date, there were approximately 9,047 holders of record of our common stock. Our transfer agent and registrar is The Bank of New York Mellon. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (800) 524-4458.

Dividends. We have not paid cash dividends on our common stock since the first quarter of fiscal 1994, and we do not intend to pay cash dividends on our common stock in the foreseeable future. We currently intend to retain earnings, if any, for the future operation and development of our business. In addition, our senior secured revolving credit agreement contains provisions that limit or prohibit the payment of cash dividends on our common stock.

Equity Compensation. Refer to Part III, Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, for information regarding securities authorized for issuance under our equity compensation plans.

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to three indices, each of which includes us. The Standard & Poor s 500 Stock Index includes 500 companies representing all major industries. The Standard & Poor s Health Care Composite Index is a group of 52 companies involved in a variety of healthcare-related businesses. Because the Standard & Poor s Health Care Composite Index is heavily weighted by pharmaceutical and medical device companies, we believe that at times it may be less useful than the Hospital Management Peer Group Index included below. We compiled this Peer Group Index by selecting publicly traded companies that have as their primary business the management of acute care hospitals and that have been in business for all five of the years shown. These companies are: Community Health Systems, Inc. (CYH), Health Management Associates, Inc. (HMA), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS).

Table of Contents

Performance data assumes that $100.00 was invested on December 31, 2004 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Stock price performance shown in the graph is not necessarily indicative of future stock price performance.

COMPARISON OF FIVE YEAR CUMULATIVE TOTAL RETURN

	12/04	12/05	12/06	12/07	12/08	12/09
Tenet Healthcare Corporation	$ 100.00	$ 69.76	$ 63.48	$ 46.27	$ 10.47	$ 49.09
S&P 500	$ 100.00	$ 104.91	$ 121.48	$ 128.16	$ 80.74	$ 102.11
S&P Health Care	$ 100.00	$ 106.46	$ 114.48	$ 122.67	$ 94.69	$ 113.34
Peer Group	$ 100.00	$ 95.87	$ 94.76	$ 73.40	$ 31.48	$ 80.78

Table of Contents

ITEM 6. SELECTED FINANCIAL DATA
OPERATING RESULTS

The following tables present selected audited consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2005 through 2009.

	Years Ended December 31,				
	2009	2008	2007	2006	2005
	(In Millions, Except Per-Share Amounts)				
Net operating revenues	**$ 9,014**	**$ 8,585**	**$ 8,083**	**$ 7,676**	**$ 7,557**
Operating expenses:					
Salaries, wages and benefits	3,857	3,779	3,617	3,440	3,468
Supplies	1,569	1,511	1,401	1,357	1,339
Provision for doubtful accounts	697	628	555	487	544
Other operating expenses, net	1,909	1,928	1,852	1,761	1,663
Depreciation and amortization	386	371	336	314	303
Impairment of long-lived assets and goodwill, and restructuring charges, net of insurance recoveries	27	16	36	312	29
Hurricane insurance recoveries, net of costs			(3)	(14)	7
Litigation and investigation costs, net of insurance recoveries	31	41	13	766	212
Operating income (loss)	**538**	**311**	**276**	**(747)**	**(8)**
Interest expense	(445)	(418)	(419)	(408)	(403)
Gain (loss) from early extinguishment of debt	97				(15)
Investment earnings		22	47	62	59
Net gain on sales of investments	15	139		5	4
Income (loss) from continuing operations, before income taxes	**205**	**54**	**(96)**	**(1,088)**	**(363)**
Income tax benefit	23	25	61	258	82
Income (loss) from continuing operations, before discontinued operations and cumulative effect of changes in accounting principle	**$ 228**	**$ 79**	**$ (35)**	**$ (830)**	**$ (281)**
Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	**$ 0.44**	**$ 0.15**	**$ (0.08)**	**$ (1.76)**	**$ (0.60)**
Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	**$ 0.43**	**$ 0.15**	**$ (0.08)**	**$ (1.76)**	**$ (0.60)**

The operating results data presented above are not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly trends in patient accounts receivable collectability and associated provisions for doubtful accounts; the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations or terminations and payer consolidations; changes in Medicare regulations; Medicaid and other funding levels set by the states in which we operate; 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; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and valuation allowances; the timing and amounts of stock option and restricted stock unit grants to employees and directors; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, our results of operations at our hospitals and related health care facilities include, but are not limited to: the business environments, economic conditions and demographics of local communities; 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 health care competitors; managed care contract negotiations or terminations; any unfavorable publicity about us, which impacts our relationships with physicians and patients; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

24

Table of Contents

BALANCE SHEET DATA

	December 31,				
	2009	2008	2007	2006	2005
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 689	$ 760	$ 512	$ 1,100	$ 1,216
Total assets	7,953	8,174	8,393	8,539	9,812
Long-term debt, net of current portion	4,272	4,778	4,771	4,760	4,784
Total equity	697	147	88	298	1,086

CASH FLOW DATA

	Years Ended December 31,				
	2009	2008	2007	2006	2005
	(In Millions)				
Net cash provided by (used in) operating activities	$ 425	$ 208	$ 326	$ (462)	$ 763
Net cash used in investing activities	(125)	(274)	(520)	(379)	(392)
Net cash provided by (used in) financing activities	(117)	1	(18)	252	348

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

INTRODUCTION TO MANAGEMENT S DISCUSSION AND ANALYSIS

The purpose of this section, Management s Discussion and Analysis of Financial Condition and Results of Operations, 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. Unless otherwise indicated, all financial and statistical information included herein relates to our continuing operations, with dollar amounts expressed in millions (except per-share, per admission, per patient day and per visit amounts). This information should be read in conjunction with the accompanying Consolidated Financial Statements. It includes the following sections:

Executive Overview

Sources of Revenue

Results of Operations

Liquidity and Capital Resources

Off-Balance Sheet Arrangements

Recently Issued Accounting Standards

Critical Accounting Estimates

EXECUTIVE OVERVIEW

We continue to focus on the execution of our operating and financing strategies. While we have seen certain areas of improvement, we are still facing several industry-wide and company-specific challenges that continue to negatively affect our progress. We are dedicated to improving our patients , shareholders and other stakeholders confidence in us. We believe we will accomplish that by providing quality care and generating positive volume growth and earnings at our hospitals.

KEY DEVELOPMENTS

Recent key developments include the following:

NorthShore Regional Medical Center Lease Not Renewed In January 2010, we entered into a definitive agreement to sell certain of our owned assets and transition the operation of NorthShore Regional Medical Center in Slidell, Louisiana to a new hospital operator. We had previously announced in May 2009 that we would not renew the lease for this hospital. We anticipate that the transaction will close effective April 1, 2010.

Repurchases of Outstanding Senior Notes In December and November 2009, we completed open market repurchases of $3 million aggregate principal amount of our 9 1/4% senior notes due 2015 and $2 million aggregate principal amount of our $6^{3}/_{8}$% senior notes due 2011 for cash of approximately $5 million. In September 2009, we repurchased approximately $8 million aggregate principal amount of our $9^{1}/_{4}$% senior notes due 2015 for cash of approximately $8 million. In July 2009, we completed open market repurchases of approximately $68 million aggregate principal amount of our 6 3/8 % senior notes due 2011, our 6 1/2% senior notes due 2012, our 9 7/8 % senior notes due 2014, and our 6 7/8 % senior notes due 2031 for cash of approximately $60 million. As a result of our July note repurchases, we recorded a gain from early extinguishment of debt of approximately $6 million in the three months ended September 30, 2009.

Table of Contents

Interest Rate Swap In November 2009, we terminated an interest rate swap agreement we had entered into effective May 1, 2009 with respect to our 7 3/8 % senior notes due 2013. We realized approximately $8 million in net savings in interest payments during the term of the interest rate swap agreement. For additional information, refer to Note 6 to the Consolidated Financial Statements included in this report.

Quality Designations In November 2009, we announced that 42 of our hospitals received 257 quality designations through CIGNA HealthCare. These quality designations are based on outcomes for treatment of 29 surgical procedures and medical conditions. In addition, 26 of our hospitals received 76 Centers of Excellence designations for 2009 from CIGNA. These designations recognize hospitals meeting CIGNA s standards for quality and efficiency. In August 2009, we announced that 29 of our hospitals received 73 UnitedHealth Premium Specialty Center designations for cardiac care, cardiac surgery and heart rhythm disorders. To receive these designations, hospitals must meet or exceed UnitedHealthcare s quality criteria based on nationally recognized medical standards.

Sale of Mandatory Convertible Preferred Stock and Repurchase of Outstanding Senior Notes with Sales Proceeds In September 2009, we sold 345,000 shares of 7% mandatory convertible preferred stock for net proceeds of approximately $334 million. We used $315 million of the net proceeds to repurchase $300 million aggregate principal amount of our outstanding 9 1/4% senior notes due 2015 in September 2009.

Private Offering of Senior Secured Notes In June 2009, we sold $925 million aggregate principal amount of 8 7/8% senior secured notes due 2019. We will pay interest on the senior secured notes semi-annually in arrears on January 1 and July 1 of each year, commencing January 1, 2010. The senior secured notes rank equally with our 9% senior secured notes due 2015 and 10% senior secured notes due 2018, which we issued in May and March 2009, as described below. All of our senior secured notes are guaranteed by and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our subsidiaries.

Tender Offer to Purchase Senior Notes In June 2009, we purchased in a cash tender offer approximately $900 million of the $1 billion aggregate principal amount outstanding of our 9 7/8% senior notes due 2014 for total consideration of approximately $941 million, representing approximately $900 million in principal payments and approximately $41 million in accrued and unpaid interest through the dates of purchase. We purchased the 9 7/8% senior notes with the net proceeds of approximately $881 million from the offering of the 8 7/8% senior secured notes due 2019 and cash on hand. In connection with the purchases of our 9 7/8% senior notes, we recorded a loss from early extinguishment of debt of approximately $24 million in the three months ended June 30, 2009.

New Joint Venture Created In May 2009, we announced the creation of MED3000 Practice Resources, LLC, a joint venture between MED3000, Inc., an unaffiliated third party, and one of our subsidiaries, which is a 20% minority owner. The new joint venture will initially focus on providing services to physician practices in the 12 states where we currently operate. In addition, the joint venture will provide health information technology (including practice management systems, electronic health records and personal health records) and management services (including revenue cycle management, group purchasing and comprehensive practice and data management).

Sale of Peoples Health Network In May 2009, we completed the sale of our 50% membership interest in Peoples Health Network (PHN), the company that administered the operations of Tenet Choices, Inc. (TCI), our wholly owned Medicare Advantage health maintenance organization insurance subsidiary in Louisiana. As part of the transaction, we transferred substantially all of the insurance assets and liabilities of TCI to a PHN subsidiary. The transaction resulted in a pretax gain in continuing operations of approximately $15 million.

Note Exchanges In May and March 2009, we exchanged approximately $918 million aggregate principal amount of our outstanding 6 3/8% senior notes due 2011 and $510 million aggregate principal amount of our outstanding 6 1/2% senior notes due 2012 for approximately $714 million aggregate principal amount of new 9% senior secured notes due 2015 and approximately $714 million aggregate principal amount of new 10% senior secured notes due 2018, plus additional consideration described in Note 6 to the Consolidated Financial Statements.

Sale of USC University Hospital and USC Kenneth Norris Jr. Cancer Hospital On March 31, 2009, we completed the previously disclosed sale of USC University Hospital and USC Kenneth Norris Jr. Cancer Hospital to the University of Southern California. The transaction generated cash proceeds of approximately $275 million from the sale of property and equipment. Approximately $30 million from these proceeds was deferred and placed in an escrow account, where they will remain for up to four years. We retained substantially all of the hospitals working capital, which is expected to result in approximately $30 million of incremental cash proceeds. The total net proceeds will be used for general corporate purposes.

Table of Contents

National Agreement with Aetna In March 2009, we announced that Tenet Physicians Inc., one of our subsidiaries, had entered into a national agreement with Aetna that covers 400 employed physicians and facilitates the participation of those physicians in Aetna s provider networks. The agreement also includes provisions promoting a joint, collaborative effort to enhance the credentialing process for the employed physicians.

SIGNIFICANT CHALLENGES

As stated above, there are a number of significant industry-wide and company-specific challenges that have been impacting our operating performance, including those summarized below.

Volumes Although we have seen some improvements in recent quarters, we have experienced declines in patient volumes over the last several years. We believe the reasons for these declines include, but are not limited to, factors that have affected many hospital companies, including decreases in the demand for invasive cardiac procedures, increased competition and utilization pressure by managed care organizations. Given our geographic concentration, we are also affected by population trends, which have been a particular concern in Florida. In addition, we believe the industry-wide challenges associated with physician recruitment, retention and attrition have also been significant contributors to our past volume declines. Our operations depend on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no contractual relationship with us. It is essential to our ongoing business that we attract and retain an appropriate number of quality physicians in all specialties on our medical staffs. Although we had a net overall gain in physicians added to our medical staffs in each of the last three years, in some of our markets, physician recruitment and retention are still affected by a shortage of physicians in certain sought-after specialties and the difficulties that physicians experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Other issues facing physicians, such as proposed decreases in Medicare payments, are forcing them to consider alternatives, including relocating their practices or retiring sooner than expected.

We continue to take steps to increase patient volumes; however, due to the concentration of our hospitals in California, Florida and Texas, we may not be able to mitigate some factors that contribute to volume declines. One of our initiatives is our *Physician Relationship Program*, which is centered on understanding the needs of physicians who admit patients both to our hospitals and to our competitors hospitals and responding to those needs with changes and improvements in our hospitals and operations. We have targeted capital spending in order to address specific needs or growth opportunities of our hospitals, which is expected to have a positive impact on their volumes. We have also sought to include all of our hospitals and an increased number of our affiliated physicians in the affected geographic area or nationally when negotiating new managed care contracts, which should result in additional volumes at facilities that were not previously a part of such managed care networks. In addition, we have completed clinical service line market demand analyses and profitability assessments to determine which services are highly valued that can be emphasized and marketed to improve our operating results. This *Targeted Growth Initiative* has resulted in some reductions in unprofitable service lines in several locations, which have had a slightly negative impact on our volumes. However, the elimination of these unprofitable service lines will allow us to focus more resources on services that are in higher demand and are more profitable.

Our *Commitment to Quality* initiative is further helping position us to competitively meet the volume challenge. We continue to work with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care. As a result of these efforts, our hospitals have improved substantially in quality metrics reported by the government and have been recognized by several managed care companies for their quality of care. In our continuing efforts to improve our clinical outcomes and drive down our costs of care, we launched our *Medicare Performance Initiative* in 2009. This initiative is focused on the identification and reduction of costs associated with variations in physician and hospital practices. The project includes the dissemination of best practices based on evidence-based medicine, which we expect will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. We believe that quality of care improvements will continue to have the effect of increasing physician and patient satisfaction, potentially improving our volumes.

Bad Debt Like other organizations in the health care industry, we continue to provide services to a high volume of uninsured patients and more patients than in prior years with an increased burden of co-payments and deductibles as a result of changes in their health care plans. The discounting components of our *Compact with Uninsured Patients* (Compact) have reduced our provision for doubtful accounts recorded in our Consolidated Financial Statements, but they do not mitigate the net economic effects of treating uninsured or underinsured patients. We continue to experience a high level of uncollectible accounts, and we continue to focus, where applicable, on placement of patients in various government programs, such as Medicaid. However, unless our business mix shifts toward a greater number of insured patients or the trend of higher co-payments and deductibles reverses, we anticipate this high level of uncollectible accounts to continue or increase.

Table of Contents

Cost Pressures Labor and supply expenses remain significant cost pressures for us as well as the industry in general. Controlling labor costs in an environment of fluctuating patient volumes and increased labor union activity will continue to be a challenge. Also, inflation and technology improvements are driving supply costs higher, and our efforts to control supply costs through product standardization, bulk purchases and improved utilization are constantly challenged.

General Economic Conditions We believe the current economic downturn, tight credit markets, and instability in the banking and financial institution industries has had some impact on our volumes and has affected our ability to collect outstanding receivables. A significant amount of our admissions comes through our emergency rooms and, therefore, is not usually materially impacted by broad economic factors. However, our levels of elective procedures and our ability to collect accounts receivable, due to the related effects of higher unemployment and reductions in commercial managed care enrollment, may be materially impacted if the current economic environment continues. We could also be negatively affected if California, Florida or other states reduce funding of Medicaid and other state health care programs.

RESULTS OF OPERATIONS OVERVIEW

Our results of operations have been and continue to be influenced by industry-wide and company-specific challenges, including fluctuating volumes, decreased demand for inpatient cardiac procedures and high levels of bad debt, that have negatively affected our revenue growth and operating expenses. We believe our future profitability will be achieved through volume growth, appropriate reimbursement levels and cost control across our portfolio of hospitals. We also believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below detailed information about these metrics for the three months ended December 31, 2009 and 2008. In order to disclose trends using data comparable to the prior-year period, operating statistics in this section and throughout Management s Discussion and Analysis are presented on a same-hospital basis, where noted, and exclude the results of our Sierra Providence East Medical Center, which opened in May 2008, and NorthShore Regional Medical Center, which was reclassified to discontinued operations in the three months ended June 30, 2009.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Admissions, Patient Days and Surgeries	**2009**	**2008**	**Increase (Decrease)**
Commercial managed care admissions	32,617	34,431	(5.3)%
Governmental managed care admissions	29,347	28,150	4.3%
Medicare admissions	38,166	39,312	(2.9)%
Medicaid admissions	16,412	15,821	3.7%
Uninsured admissions	5,742	5,956	(3.6)%
Charity care admissions	2,487	2,254	10.3%
Other admissions	3,257	3,311	(1.6)%
Total admissions	128,028	129,235	(0.9)%
Paying admissions (excludes charity and uninsured)	119,799	121,025	(1.0)%
Total government program admissions	83,925	83,283	0.8%
Charity admissions and uninsured admissions	8,229	8,210	0.2%
Admissions through emergency department	73,806	73,000	1.1%
Commercial managed care admissions as a percentage of total admissions	25.5%	26.6%	(1.1)%(1)
Emergency department admissions as a percentage of total admissions	57.6%	56.5%	1.1% (1)
Uninsured admissions as a percentage of total admissions	4.5%	4.6%	(0.1)%(1)
Charity admissions as a percentage of total admissions	1.9%	1.7%	0.2% (1)
Surgeries inpatient	37,663	38,296	(1.7)%
Surgeries outpatient	52,092	51,448	1.3%
Total surgeries	89,755	89,744	%
Patient days total	622,475	630,821	(1.3)%
Adjusted patient days(2)	920,652	918,560	0.2%
Patient days commercial managed care	130,289	136,976	(4.9)%
Average length of stay (days)	4.9	4.9	(1)
Adjusted patient admissions(2)	190,619	189,357	0.7%

(1) The change is the difference between the amounts shown for the three months ended December 31, 2009 as compared to the three months ended December 31, 2008.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Table of Contents

Total same-hospital admissions declined by 1,207, or 0.9%, in the three months ended December 31, 2009 as compared to the same period in 2008. Our California region and our Philadelphia market each reported positive total admissions growth, while our other regions reported admissions declines, in the three months ended December 31, 2009 as compared to the three months ended December 31, 2008. Commercial managed care admissions declined by 5.3% in the three months ended December 31, 2009 as compared to the same period in 2008. Admissions through all government programs, including both traditional and managed government programs, achieved positive growth of 0.8% in the three months ended December 31, 2009 as compared to the three months ended December 31, 2008. Uninsured and charity admissions grew by 0.2% in the three months ended December 31, 2009 as compared to the same period in 2008. There were 666 flu-related admissions in the three months ended December 31, 2009.