

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR EXEMPTION FOR THE CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY

ORIGINAL

E-005-15

RECEIVED

JUL 24 2015

1. INFORMATION FOR EXISTING FACILITY

Current Facility Name Effingham Ambulatory Surgery Center
Address 904 West Temple Street
City Effingham, IL Zip Code 62401 County Effingham
Name of current licensed entity for the facility Effingham Surgical Partners, LLC
Does the current licensee: own this facility OR lease this facility X (if leased, check if sublease )
Type of ownership of the current licensed entity (check one of the following:) Sole Proprietorship
Not-for-Profit Corporation For Profit Corporation Partnership Governmental
X Limited Liability Company Other, specify
Illinois State Senator for the district where the facility is located: Sen. Kyle McCarter
State Senate District Number 54 Mailing address of the State Senator
103C Capitol Building Springfield, IL 62706
Illinois State Representative for the district where the facility is located: Rep. John D. Cavaletto
State Representative District Number 107 Mailing address of the State Representative
205-N Stratton Office Building Springfield, IL 62706

HEALTH FACILITIES & SERVICES REVIEW BOARD

2. OUTSTANDING PERMITS. Does the facility have any projects for which the State Board issued a permit that will not be completed (refer to 1130.140 "Completion or Project Completion" for a definition of project completion) by the time of the proposed ownership change? Yes No X. If yes, refer to Section 1130.520(f), and indicate the projects by Project #

3. NAME OF APPLICANT (complete this information for each co-applicant and insert after this page).

Exact Legal Name of Applicant please see following page
Address
City, State & Zip Code
Type of ownership of the current licensed entity (check one of the following:) Sole Proprietorship
Not-for-Profit Corporation For Profit Corporation Partnership Governmental Limited Liability Company Other, specify

4. NAME OF LEGAL ENTITY THAT WILL BE THE LICENSEE/OPERATING ENTITY OF THE FACILITY NAMED IN THE APPLICATION AS A RESULT OF THIS TRANSACTION.

Exact Legal Name of Entity to be Licensed Effingham Surgical Partners, LLC
Address 904 West Temple Street
City, State & Zip Code Effingham, IL 62401
Type of ownership of the current licensed entity (check one of the following:) Sole Proprietorship Not-for-Profit Corporation For Profit Corporation Partnership Governmental X Limited Liability Company
Other, specify

5. BUILDING/SITE OWNERSHIP. NAME OF LEGAL ENTITY THAT WILL OWN THE "BRICKS AND MORTAR" (BUILDING) OF THE FACILITY NAMED IN THIS APPLICATION IF DIFFERENT FROM THE OPERATING/LICENSED ENTITY

Exact Legal Name of Entity That Will Own the Site Effingham Medical Properties
Address 900 West Temple Street
City, State & Zip Code Effingham, IL 62401
Type of ownership of the current licensed entity (check one of the following:) Sole Proprietorship
Not-for-Profit Corporation For Profit Corporation X Partnership Governmental Limited Liability Company Other, specify

**6. TRANSACTION TYPE. CHECK THE FOLLOWING THAT APPLY TO THE TRANSACTION:**

- Purchase resulting in the issuance of a license to an entity different from current licensee;
- Lease resulting in the issuance of a license to an entity different from current licensee;
- Stock transfer resulting in the issuance of a license to a different entity from current licensee;
- Stock transfer resulting in no change from current licensee;
- Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee;
- Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee;
- Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity;
- Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets;
- Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility;
- Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee;
- Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets, and explain in "Attachment 3 Narrative Description"

**7. APPLICATION FEE.** Submit the application fee in the form of a check or money order for \$2,500 payable to the Illinois Department of Public Health and append as **ATTACHMENT #1**.

**8. FUNDING.** Indicate the type and source of funds which will be used to acquire the facility (e.g., mortgage through Health Facilities Authority; cash gift from parent company, etc.) and append as **ATTACHMENT #2**.

**9. ANTICIPATED ACQUISITION PRICE:** \$ 3,644,789

**10. FAIR MARKET VALUE OF THE FACILITY:** \$ 3,644,789

(to determine fair market value, refer to 77 IAC 1130.140)

**11. DATE OF PROPOSED TRANSACTION:** within 30 days of receipt of COE

**12. NARRATIVE DESCRIPTION.** Provide a narrative description explaining the transaction, and append it to the application as **ATTACHMENT #3**.

**13. BACKGROUND OF APPLICANT** (co-applicants must also provide this information). Corporations and Limited Liability Companies must provide a current Certificate of Good Standing from the Illinois Secretary of State. Limited Liability Companies and Partnerships must provide the name and address of each partner/ member and specify the percentage of ownership of each. Append this information to the application as **ATTACHMENT #4**.

**14. TRANSACTION DOCUMENTS.** Provide a copy of the complete transaction document(s) including schedules and exhibits which detail the terms and conditions of the proposed transaction (purchase, lease, stock transfer, etc). Applicants should note that the document(s) submitted should reflect the applicant's (and co-applicant's, if applicable) involvement in the transaction. The document must be signed by both parties and contain language stating that the transaction is contingent upon approval of the Illinois Health Facilities and Services Review Board. Append this document(s) to the application as **ATTACHMENT #5**.

**15. FINANCIAL STATEMENTS.** (Co-applicants must also provide this information) Provide a copy of the applicants latest audited financial statements, and append it to this application as **ATTACHMENT #6**. If the applicant is a newly formed entity and financial statements are not available, please indicate by checking YES  , and indicate the date the entity was formed \_\_\_\_\_

**Applicants:**

Name: Tenet Healthcare Corporation  
Address: 1445 Ross Avenue Suite 1400 Dallas, TX 75202  
Type of Ownership: For Profit Corporation

Name: Effingham Surgical Partners, LLC  
Address: 904 West Temple Street Effingham, IL 62401  
Type of Ownership: Limited Liability Company

Name: USP Effingham, Inc.  
Address: 904 West Temple Street Effingham, IL 62401  
Type of Ownership: For Profit Corporation

Name: United Surgical Partners International  
Address: 15305 Dallas Parkway Suite 1600 Addison, TX 75001  
Type of Ownership: For Profit Corporation

**16. PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

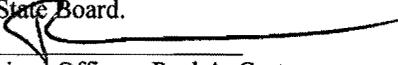
Name: Jacob M. Axel  
Address: 675 North Court, Suite 210  
City, State & Zip Code: Palatine, IL 60067  
Telephone ( ) Ext. 847/776-7101

**17. ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: none  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Telephone ( ) Ext. \_\_\_\_\_

**18. CERTIFICATION**

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the number of beds within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer   
Typed or Printed Name of Authorized Officer Paul A. Castanon  
Title of Authorized Officer: Secretary  
Address: 1445 Ross Avenue, Suite 1400  
City, State & Zip Code: Dallas, Texas 75202  
Telephone (469)893-2000 Date: July 17, 2015

**NOTE: complete a separate signature page for each co-applicant and insert following this page.**

**16. PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

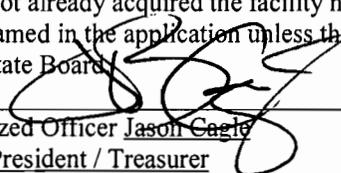
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Address: 675 North Court, Suite 210  
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Telephone ( ) Ext. 847/776-7101

**17. ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: none  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Telephone ( ) Ext. \_\_\_\_\_

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Signature of Authorized Officer   
Typed or Printed Name of Authorized Officer Jason Cagle  
Title of Authorized Officer: Vice President / Treasurer  
Address: 15305 Dallas Pkwy #1600  
City, State & Zip Code: Addison, TX 75001  
Telephone (972) 713-3568      Date: \_\_\_\_\_

**NOTE: complete a separate signature page for each co-applicant and insert following this page.**

**Effingham Surgical Partners, LLC**

**16. PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

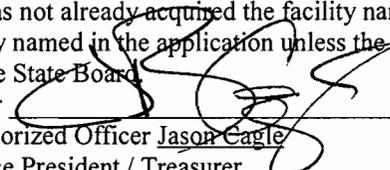
Name: Jacob M. Axel  
Address: 675 North Court, Suite 210  
City, State & Zip Code: Palatine, IL 60067  
Telephone ( ) Ext. 847/776-7101

**17. ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: none  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Telephone ( ) Ext. \_\_\_\_\_

**18. CERTIFICATION**

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Signature of Authorized Officer 

Typed or Printed Name of Authorized Officer Jason Cagle

Title of Authorized Officer: Vice President / Treasurer

Address: 15305 Dallas Pkwy #1600

City, State & Zip Code: Addison, TX 75001

Telephone (972) 713-3568      Date: \_\_\_\_\_

**NOTE: complete a separate signature page for each co-applicant and insert following this page.**

**USP Effingham, Inc.**

**16. PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

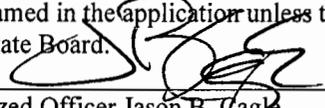
Name: Jacob M. Axel  
Address: 675 North Court, Suite 210  
City, State & Zip Code: Palatine, IL 60067  
Telephone ( ) Ext. 847/776-7101

**17. ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: none  
Address: \_\_\_\_\_  
City, State & Zip Code: \_\_\_\_\_  
Telephone ( ) Ext. \_\_\_\_\_

**18. CERTIFICATION**

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the number of beds within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer   
Typed or Printed Name of Authorized Officer Jason B. Cagle  
Title of Authorized Officer: Senior Vice President / CFO / Treasurer  
Address: 15305 Dallas Pkwy #1600  
City, State & Zip Code: Addison, TX 75001  
Telephone (972) 713-3568      Date: \_\_\_\_\_

**NOTE: complete a separate signature page for each co-applicant and insert following this page.**

**United Surgical Partners International**

8051

AXEL & ASSOCIATES, INC.

DATE 7/17/15

2-7080-2710

PAY TO THE ORDER OF

ILLINOIS DEPARTMENT OF Public Health

\$ 2500<sup>00</sup>

two thousand five hundred and No/100 DOLLARS

**citibank**  
CITIBANK N.A. BR. #86  
333 EAST NORTHWEST HIGHWAY  
PALATINE, IL 60067

FOR

EFFINGHAM

*[Handwritten Signature]*



⑈008051⑈ ⑆271070801⑆0980001199⑈



June 25, 2015

Ms. Courtney Avery  
Illinois Health Facility and Services Review Board  
525 West Jefferson  
Springfield, IL 62761

Dear Ms. Avery:

The total estimated project costs related to the change of ownership of Effingham Surgery Center will be funded in total with cash and equivalents.

Very truly yours,

Daniel J. Cancelmi  
Chief Financial Officer

STATE OF TEXAS        )  
  )  
COUNTY OF DALLAS    )

BEFORE ME, the undersigned notary public, duly commissioned and qualified in the state and county aforesaid, personally appeared Daniel J. Cancelmi, Chief Financial Officer of Tenet Healthcare Corporation, a Delaware corporation, known to be the person who signed the foregoing instrument and acknowledged that she did execute the instrument for the purposes state herein.

SWORN TO and subscribed before me this 25 day of June 2015.



Notary Public  
My Commission Expires: 9/30/2015

## Narrative Description

On June 16, 2015 a transaction between Tenet Healthcare Corporation (“Tenet”) and Welsh, Cason Anderson & Stowe and valued at \$425 million, was completed through which Tenet secured a controlling interest in United Surgical Partners International (USPI).

At the time of the closing, USPI held an ownership interest in six ambulatory surgical treatment centers (“ASTCs”) in Illinois, and 243 surgery centers outside of Illinois. Through multiple technical assistance discussions with IHFSRB staff in late March and early April 2015, a determination was made that, as a result of USPI’s minority interest in five of those ASTCs, IHFSRB review and action regarding those ASTCs was not required.

USPI, through its subsidiary USP Effingham, Inc., holds a “controlling” interest (53.63%) in Effingham Surgical Partners, LLC, which owns Effingham Ambulatory Surgery Center (EASC), a 5-operating room multi-specialty surgery center located at 904 W. Temple Street in Effingham, Illinois. As a result of USP Effingham, Inc.’s controlling interest in EASC, the determination was made by IHFSRB staff that IHFSRB approval was required.

The transaction described above addressed the remaining 248 surgery centers, with EASC being “broken out” of that transaction, allowing that transaction to close on June 16<sup>th</sup>, and to be in compliance with IHFSRB pre-closing approval requirements.

Tenet Healthcare Corporation has been named as an applicant as a result of its proposed “ultimate control”.

Effingham Surgical Partners, LLC has been named as an applicant as a result of its role as the current and continuing license holder.

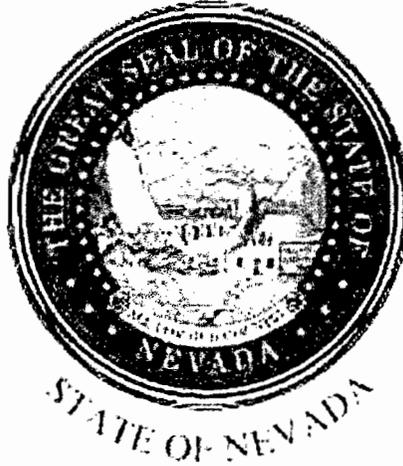
USP Effingham, Inc. has been named as an applicant as a result of its current controlling interest in the license holder.

United Surgical Partners International has been named as an applicant as a result of its current “ultimate control” over USP Effingham, Inc.

The anticipated acquisition price identified in item 9 is based on the ratio of the EBITDA of Effingham Ambulatory Surgery Center to that of all 249 surgery centers being acquired.

This is a “non-substantive” project because it does not involve the establishment or discontinuation of a licensed health care facility or an IHFSRB-designated category of service.

# SECRETARY OF STATE



## CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, BARBARA K. CEGAVSKE, the duly elected and qualified Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporation soles, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada Revised Statutes which are either presently in a status of good standing or were in good standing for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **TENET HEALTHCARE CORPORATION**, as a corporation duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since November 7, 1975, and is in good standing in this state.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on July 13, 2015.

*Barbara K. Cegavske*

BARBARA K. CEGAVSKE  
Secretary of State

Electronic Certificate  
Certificate Number: C20150713-1138  
You may verify this electronic certificate  
online at <http://www.nvsos.gov/>

ATTACHMENT 4

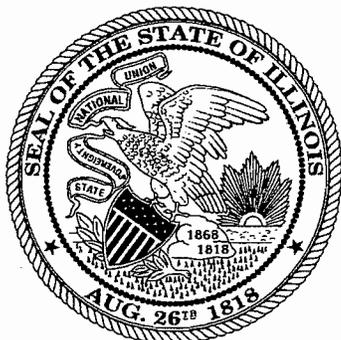


**To all to whom these Presents Shall Come, Greeting:**

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

EFFINGHAM SURGICAL PARTNERS, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MARCH 02, 2000, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 29TH day of JUNE A.D. 2015 .***



Authentication #: 1518001310 verifiable until 06/29/2016  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE ATTACHMENT 4

# Delaware

PAGE 1

## The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "UNITED SURGICAL PARTNERS INTERNATIONAL, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-FIRST DAY OF JULY, A.D. 2015.

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

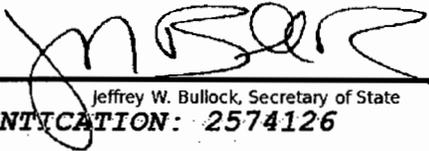
AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

2865387 8300

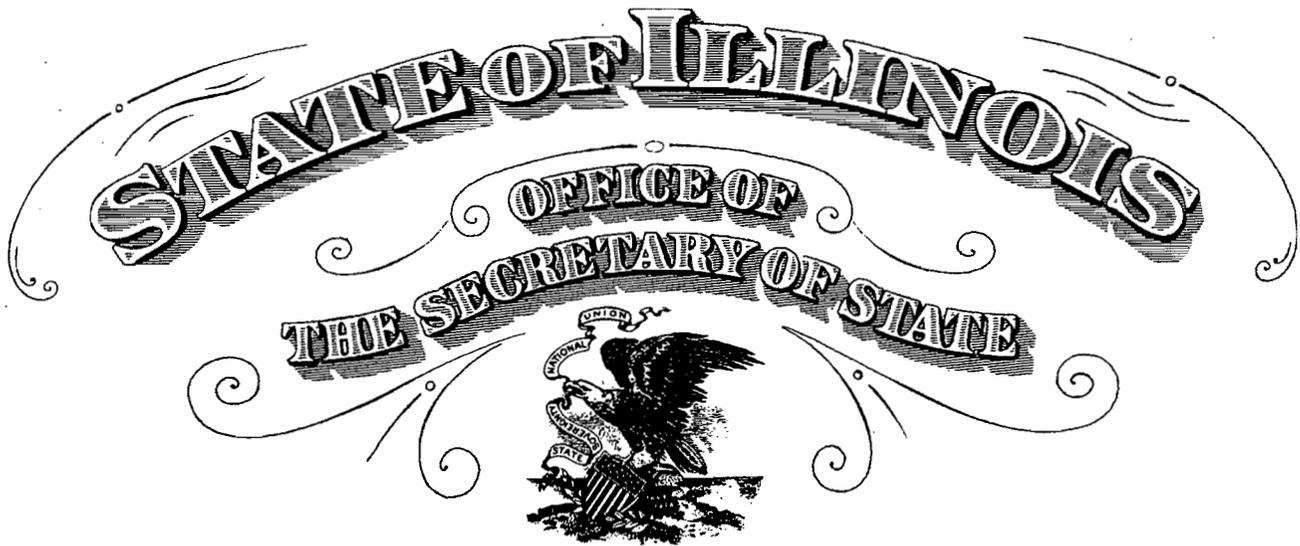
151073044

You may verify this certificate online  
at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)



  
Jeffrey W. Bullock, Secretary of State  
AUTHENTICATION: 2574126

DATE: 07-21-15  
ATTACHMENT 4



**To all to whom these Presents Shall Come, Greeting:**

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

USP EFFINGHAM, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 25, 2012, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 7TH day of JULY A.D. 2015 .***

*Jesse White*

SECRETARY OF STATE ATTACHMENT 4

**ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA****MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING**

To Our Shareholders:

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended. Management assessed the effectiveness of Tenet's internal control over financial reporting as of December 31, 2014. This assessment was performed under the supervision of and with the participation of management, including the chief executive officer and chief financial officer.

In making this assessment, management used criteria based on the framework in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on the assessment using the COSO framework, management concluded that Tenet's internal control over financial reporting was effective as of December 31, 2014.

Tenet's internal control over financial reporting as of December 31, 2014 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report, which is included herein. Deloitte & Touche LLP has also audited Tenet's Consolidated Financial Statements as of and for the year ended December 31, 2014, and that firm's audit report on such Consolidated Financial Statements is also included herein.

Internal control over financial reporting cannot provide absolute assurance of achieving financial reporting objectives because of its inherent limitations. Internal control over financial reporting is a process that involves human diligence and compliance and is subject to lapses in judgment and breakdowns resulting from human failures. Internal control over financial reporting also can be circumvented by collusion or improper management override. Because of such limitations, there is a risk that material misstatements may not be prevented or detected on a timely basis by internal control over financial reporting. However, these inherent limitations are known features of the financial reporting process. Therefore, it is possible to design into the process safeguards to reduce, though not eliminate, this risk.

/s/ TREVOR FETTER  
Trevor Fetter  
*President and Chief Executive Officer*  
February 23, 2015

/s/ DANIEL J. CANCELMI  
Daniel J. Cancelmi  
*Chief Financial Officer*  
February 23, 2015

Table of Contents**REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

To the Board of Directors and Stockholders of  
Tenet Healthcare Corporation  
Dallas, Texas

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2014, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2014 of the Company and our report dated February 23, 2015 expressed an unqualified opinion on those financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP  
Dallas, Texas  
February 23, 2015

Table of Contents**REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

To the Board of Directors and Stockholders of  
Tenet Healthcare Corporation  
Dallas, Texas

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2014 and 2013, and the related consolidated statements of operations, other comprehensive income (loss), changes in equity, and cash flows for each of the three years in the period ended December 31, 2014. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Tenet Healthcare Corporation and subsidiaries at December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2014, based on the criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 23, 2015 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP  
Dallas, Texas  
February 23, 2015

Table of Contents**CONSOLIDATED BALANCE SHEETS**  
Dollars in Millions

	<u>December 31, 2014</u>	<u>December 31, 2013</u>
<b>ASSETS</b>		
<b>Current assets:</b>		
Cash and cash equivalents	\$ 193	\$ 113
Accounts receivable, less allowance for doubtful accounts (\$852 at December 31, 2014 and \$589 at December 31, 2013)	2,404	1,890
Inventories of supplies, at cost	276	260
Income tax receivable	2	—
Current portion of deferred income taxes	747	692
Other current assets	1,095	737
<b>Total current assets</b>	<b>4,717</b>	<b>3,692</b>
Investments and other assets	384	357
Deferred income taxes, net of current portion	116	148
Property and equipment, at cost, less accumulated depreciation and amortization (\$4,478 at December 31, 2014 and \$3,907 at December 31, 2013)	7,733	7,582
Goodwill	3,913	3,566
Other intangible assets, at cost, less accumulated amortization (\$671 at December 31, 2014 and \$516 at December 31, 2013)	1,278	1,105
<b>Total assets</b>	<b>\$ 18,141</b>	<b>\$ 16,450</b>
<b>LIABILITIES AND EQUITY</b>		
<b>Current liabilities:</b>		
Current portion of long-term debt	\$ 112	\$ 153
Accounts payable	1,179	1,085
Accrued compensation and benefits	852	622
Professional and general liability reserves	189	156
Accrued interest payable	194	198
Other current liabilities	1,051	879
<b>Total current liabilities</b>	<b>3,577</b>	<b>3,093</b>
Long-term debt, net of current portion	11,695	10,696
Professional and general liability reserves	492	555
Defined benefit plan obligations	633	398
Other long-term liabilities	558	490
<b>Total liabilities</b>	<b>16,955</b>	<b>15,232</b>
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	401	340
<b>Equity:</b>		
<b>Shareholders' equity:</b>		
Common stock, \$0.05 par value; authorized 262,500,000 shares; 145,578,735 shares issued at December 31, 2014 and 144,057,351 shares issued at December 31, 2013	7	7
Additional paid-in capital	4,614	4,572
Accumulated other comprehensive loss	(182)	(24)
Accumulated deficit	(1,410)	(1,422)
Common stock in treasury, at cost, 47,196,902 shares at December 31, 2014 and 47,197,722 shares at December 31, 2013	(2,378)	(2,378)
<b>Total shareholders' equity</b>	<b>651</b>	<b>755</b>
<b>Noncontrolling interests</b>	<b>134</b>	<b>123</b>
<b>Total equity</b>	<b>785</b>	<b>878</b>
<b>Total liabilities and equity</b>	<b>\$ 18,141</b>	<b>\$ 16,450</b>

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

**CONSOLIDATED STATEMENTS OF OPERATIONS**  
Dollars in Millions, Except Per-Share Amounts

	Years Ended December 31,		
	2014	2013	2012
<b>Net operating revenues:</b>			
Net operating revenues before provision for doubtful accounts	\$ 17,920	\$ 12,074	\$ 9,904
Less: Provision for doubtful accounts	1,305	972	785
<b>Net operating revenues</b>	<b>16,615</b>	<b>11,102</b>	<b>9,119</b>
<b>Operating expenses:</b>			
Salaries, wages and benefits	8,023	5,371	4,257
Supplies	2,630	1,784	1,552
Other operating expenses, net	4,114	2,701	2,147
Electronic health record incentives	(104)	(96)	(40)
Depreciation and amortization	849	545	430
Impairment and restructuring charges, and acquisition-related costs	153	103	19
Litigation and investigation costs	25	31	5
<b>Operating income</b>	<b>925</b>	<b>663</b>	<b>749</b>
Interest expense	(754)	(474)	(412)
Loss from early extinguishment of debt	(24)	(348)	(4)
Investment earnings	—	1	1
<b>Net income (loss) from continuing operations, before income taxes</b>	<b>147</b>	<b>(158)</b>	<b>334</b>
Income tax benefit (expense)	(49)	65	(125)
<b>Net income (loss) from continuing operations, before discontinued operations</b>	<b>98</b>	<b>(93)</b>	<b>209</b>
<b>Discontinued operations:</b>			
Loss from operations	(17)	(5)	(2)
Impairment of long-lived assets and goodwill	—	—	(100)
Litigation and investigation costs	(18)	(2)	—
Net gains on sale of facilities	—	—	1
Income tax benefit (expense)	13	(4)	25
<b>Net loss from discontinued operations</b>	<b>(22)</b>	<b>(11)</b>	<b>(76)</b>
<b>Net income (loss)</b>	<b>76</b>	<b>(104)</b>	<b>133</b>
Less: Preferred stock dividends	—	—	11
Less: Net income (loss) attributable to noncontrolling interests			
Continuing operations	64	30	13
Discontinued operations	—	—	(32)
<b>Net income (loss) attributable to Tenet Healthcare Corporation common shareholders</b>	<b>\$ 12</b>	<b>\$ (134)</b>	<b>\$ 141</b>
<b>Amounts attributable to Tenet Healthcare Corporation common shareholders</b>			
Net income (loss) from continuing operations, net of tax	\$ 34	\$ (123)	\$ 185
Net loss from discontinued operations, net of tax	(22)	(11)	(44)
<b>Net income (loss) attributable to Tenet Healthcare Corporation common shareholders</b>	<b>\$ 12</b>	<b>\$ (134)</b>	<b>\$ 141</b>
<b>Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:</b>			
<b>Basic</b>			
Continuing operations	\$ 0.35	\$ (1.21)	\$ 1.77
Discontinued operations	(0.23)	(0.11)	(0.42)
	<b>\$ 0.12</b>	<b>\$ (1.32)</b>	<b>\$ 1.35</b>
<b>Diluted</b>			
Continuing operations	\$ 0.34	\$ (1.21)	\$ 1.70
Discontinued operations	(0.22)	(0.11)	(0.40)
	<b>\$ 0.12</b>	<b>\$ (1.32)</b>	<b>\$ 1.30</b>
<b>Weighted average shares and dilutive securities outstanding (in thousands):</b>			
Basic	97,801	101,648	104,200
Diluted	100,287	101,648	108,926

See accompanying Notes to Consolidated Financial Statements.

ATTACHMENT 6

19

ATTACHMENT 6

20

Table of Contents**CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME (LOSS)**  
Dollars in Millions

	Years Ended December 31,		
	2014	2013	2012
Net income (loss)	\$ 76	\$ (104)	\$ 133
Other comprehensive income (loss):			
Adjustments for defined benefit plans	(258)	68	(25)
Amortization of prior-year service costs included in net periodic benefit costs	4	1	—
Unrealized gains on securities held as available-for-sale	3	—	—
<b>Other comprehensive income (loss) before income taxes</b>	<b>(251)</b>	<b>69</b>	<b>(25)</b>
Income tax benefit (expense) related to items of other comprehensive income (loss)	93	(25)	9
<b>Total other comprehensive income (loss), net of tax</b>	<b>(158)</b>	<b>44</b>	<b>(16)</b>
<b>Comprehensive net income (loss)</b>	<b>(82)</b>	<b>(60)</b>	<b>117</b>
Less: Preferred stock dividends	—	—	11
<b>Less: Comprehensive income (loss) attributable to noncontrolling interests</b>	<b>64</b>	<b>30</b>	<b>(19)</b>
<b>Comprehensive net income (loss) attributable to Tenet Healthcare Corporation common shareholders</b>	<b>\$ (146)</b>	<b>\$ (90)</b>	<b>\$ 125</b>

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

**CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY**  
**Dollars in Millions,**  
**Share Amounts in Thousands**

Tenet Healthcare Corporation Shareholders' Equity										
	Preferred Stock		Common Stock		Accumulated			Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Amount	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Other Comprehensive Loss	Accumulated Deficit			
Balances at December 31, 2011	345	\$ 334	103,756	\$ 7	\$ 4,427	\$ (52)	\$ (1,440)	\$ (1,853)	\$ 69	\$ 1,492
Net income (loss)	—	—	—	—	—	—	152	—	(22)	130
Distributions paid to noncontrolling interests	—	—	—	—	—	—	—	—	(12)	(12)
Contributions from noncontrolling interests	—	—	—	—	—	—	—	—	3	3
Other comprehensive loss	—	—	—	—	—	(16)	—	—	—	(16)
Purchases of businesses or joint venture interests	—	—	—	—	—	—	—	—	37	37
Preferred stock dividends	—	—	—	—	(11)	—	—	—	—	(11)
Repurchases of common stock	—	—	(4,733)	—	—	—	—	(126)	—	(126)
Repurchases of preferred stock	(299)	(289)	—	—	—	—	—	—	—	(289)
Conversion of preferred stock to common stock	(46)	(45)	1,979	—	45	—	—	—	—	—
Stock-based compensation expense and issuance of common stock	—	—	3,631	—	10	—	—	—	—	10
Balances at December 31, 2012	—	\$ —	104,633	\$ 7	\$ 4,471	\$ (68)	\$ (1,288)	\$ (1,979)	\$ 75	\$ 1,218
Net income (loss)	—	—	—	—	—	—	(134)	—	21	(113)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	—	—	(22)	(22)
Other comprehensive income	—	—	—	—	—	44	—	—	—	44
Contributions from noncontrolling interests	—	—	—	—	56	—	—	—	49	105
Repurchases of common stock	—	—	(9,485)	—	—	—	—	(400)	—	(400)
Stock-based compensation expense and issuance of common stock	—	—	1,712	—	45	—	—	1	—	46
Balances at December 31, 2013	—	\$ —	96,860	\$ 7	\$ 4,572	\$ (24)	\$ (1,422)	\$ (2,378)	\$ 123	\$ 878
Net income	—	—	—	—	—	—	12	—	31	43
Distributions paid to noncontrolling interests	—	—	—	—	—	—	—	—	(37)	(37)
Contributions from noncontrolling interests	—	—	—	—	—	—	—	—	7	7
Other comprehensive income	—	—	—	—	—	(158)	—	—	—	(158)
Purchases (sales) of businesses or joint venture interests	—	—	—	—	(22)	—	—	—	10	(12)
Stock-based compensation expense and issuance of common stock	—	—	1,522	—	64	—	—	—	—	64
Balances at December 31, 2014	—	\$ —	98,382	\$ 7	\$ 4,614	\$ (182)	\$ (1,410)	\$ (2,378)	\$ 134	\$ 785

See accompanying Notes to Consolidated Financial Statements.

Table of Contents

**CONSOLIDATED STATEMENTS OF CASH FLOWS**  
Dollars in Millions

	<u>Years Ended December 31,</u>		
	<u>2014</u>	<u>2013</u>	<u>2012</u>
<b>Net income (loss)</b>	\$ 76	\$ (104)	\$ 133
<b>Adjustments to reconcile net income (loss) to net cash provided by operating activities:</b>			
Depreciation and amortization	849	545	430
Provision for doubtful accounts	1,305	972	785
Deferred income tax expense (benefit)	30	(67)	92
Stock-based compensation expense	51	36	32
Impairment and restructuring charges, and acquisition-related costs	153	103	19
Litigation and investigation costs	25	31	5
Loss from early extinguishment of debt	24	348	4
Amortization of debt discount and debt issuance costs	28	19	22
Pre-tax loss from discontinued operations	35	7	101
Other items, net	(40)	(33)	(12)
<b>Changes in cash from operating assets and liabilities:</b>			
Accounts receivable	(1,896)	(987)	(868)
Inventories and other current assets	(314)	(203)	(59)
Income taxes	3	—	(5)
Accounts payable, accrued expenses and other current liabilities	505	38	9
Other long-term liabilities	44	13	3
<b>Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements</b>	<b>(168)</b>	<b>(114)</b>	<b>(63)</b>
<b>Net cash used in operating activities from discontinued operations, excluding income taxes</b>	<b>(23)</b>	<b>(15)</b>	<b>(35)</b>
<b>Net cash provided by operating activities</b>	<b>687</b>	<b>589</b>	<b>593</b>
<b>Cash flows from investing activities:</b>			
Purchases of property and equipment — continuing operations	(933)	(691)	(506)
Purchases of property and equipment — discontinued operations	—	—	(2)
Purchases of businesses or joint venture interests, net of cash acquired	(428)	(1,515)	(211)
Proceeds from sales of facilities and other assets — discontinued operations	6	16	45
Proceeds from sales of marketable securities, long-term investments and other assets	31	15	17
Other long-term assets	1	8	(9)
Other items, net	1	3	4
<b>Net cash used in investing activities</b>	<b>(1,322)</b>	<b>(2,164)</b>	<b>(662)</b>
<b>Cash flows from financing activities:</b>			
Repayments of borrowings under credit facility	(2,430)	(1,286)	(1,773)
Proceeds from borrowings under credit facility	2,245	1,691	1,693
Repayments of other borrowings	(683)	(5,133)	(248)
Proceeds from other borrowings	1,608	6,507	1,092
Repurchases of preferred stock	—	—	(292)
Repurchases of common stock	—	(400)	(126)
Cash dividends on preferred stock	—	—	(14)
Deferred debt issuance costs	(27)	(154)	(17)
Distributions paid to noncontrolling interests	(45)	(27)	(15)
Contributions from noncontrolling interests	18	99	3
Proceeds from exercise of stock options	26	22	11
Other items, net	3	5	6
<b>Net cash provided by financing activities</b>	<b>715</b>	<b>1,324</b>	<b>320</b>
Net increase (decrease) in cash and cash equivalents	80	(251)	251
Cash and cash equivalents at beginning of period	113	364	113
<b>Cash and cash equivalents at end of period</b>	<b>\$ 193</b>	<b>\$ 113</b>	<b>\$ 364</b>
<b>Supplemental disclosures:</b>			
Interest paid, net of capitalized interest	\$ (726)	\$ (426)	\$ (376)
Income tax payments, net	\$ (8)	\$ (6)	\$ (13)

See accompanying Notes to Consolidated Financial Statements.

ATTACHMENT 6

23

ATTACHMENT 6

24

Table of Contents**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS****NOTE 1. SIGNIFICANT ACCOUNTING POLICIES***Description of Business*

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a national, diversified healthcare services company. As of December 31, 2014 we operated 80 hospitals, 210 outpatient centers, six health plans, and Conifer Health Solutions, LLC ("Conifer"), which provides healthcare business process services in the areas of revenue cycle management, value-based care and patient communications.

Effective October 1, 2013, we acquired the common stock of Vanguard Health Systems, Inc. ("Vanguard") for \$21 per share in an all cash transaction. Vanguard owned and operated 28 hospitals (plus one more under construction, which was completed in June 2014), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas. We paid approximately \$4.3 billion to acquire Vanguard, including the assumption of \$2.5 billion of Vanguard's net debt.

*Basis of Presentation*

Our Consolidated Financial Statements include the accounts of Tenet and its wholly owned and majority-owned subsidiaries. We eliminate intercompany accounts and transactions in consolidation, and we include the results of operations of businesses that are newly acquired in purchase transactions from their dates of acquisition. We account for significant investments in other affiliated companies using the equity method. Unless otherwise indicated, all financial and statistical data included in these notes to our Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). The accompanying Consolidated Balance Sheet as of December 31, 2013 has been revised to reflect the impact of completing the purchase price allocation for the acquisition of Vanguard, as described in Note 19. Furthermore, all amounts related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for the reverse stock split described in Note 2.

*Use of Estimates*

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

*Net Operating Revenues Before Provision for Doubtful Accounts*

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("Compact") and other uninsured discount and charity programs.



We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted. Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2014, 2013 and 2012 by \$20 million, \$38 million, and \$114 million (in 2012, \$81 million related to the industry-wide Medicare Budget Neutrality settlement), respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Consolidated Balance Sheets (see Note 3). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

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

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



Table of Contents

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

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as Indirect Medical Education, Direct Graduate Medical Education, disproportionate share hospital and bad debt expense, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change

Table of Contents

Under our Compact or other uninsured discount programs, the discount offered to certain uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

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

The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Years Ended December 31,		
	2014	2013	2012
<b>General Hospitals:</b>			
Medicare	\$ 3,452	\$ 2,357	\$ 2,195
Medicaid	1,485	975	783
Managed care	9,250	6,277	5,382
Indemnity, self-pay and other	1,602	1,201	1,007
Acute care hospitals — other revenue	54	78	69
<b>Other:</b>			
Other operations	2,077	1,186	468
<b>Net operating revenues before provision for doubtful accounts</b>	<b>\$ 17,920</b>	<b>\$ 12,074</b>	<b>\$ 9,904</b>

*Provision for Doubtful Accounts*

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

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to

Table of Contents

be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

***Electronic Health Record Incentives***

Under certain provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"), federal incentive payments are available to hospitals, physicians and certain other professionals when they adopt, implement or upgrade ("AIU") certified electronic health record ("EHR") technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. Hospitals that are meaningful users under the Medicare EHR incentive payment program are deemed meaningful users under the Medicaid EHR incentive payment program and do not need to meet additional criteria imposed by a state. Medicaid EHR incentive payments to providers are 100% federally funded and administered by the states. The Centers for Medicare and Medicaid Services ("CMS") established calendar year 2011 as the first year states could offer EHR incentive payments. Before a state may offer EHR incentive payments, the state must submit and CMS must approve the state's incentive plan.

We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved. During the years ended December 31, 2014, 2013 and 2012, certain of our hospitals and physicians satisfied the CMS AIU and/or meaningful use criteria. As a result, we recognized approximately \$104 million, \$96 million and \$40 million of Medicare and Medicaid EHR incentive payments as a reduction to expense in our Consolidated Statement of Operations for the years ended December 31, 2014, 2013 and 2012, respectively.

***Cash and Cash Equivalents***

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately \$193 million and \$113 million at December 31, 2014 and 2013, respectively. As of December 31, 2014 and 2013, our book overdrafts were approximately \$264 million and \$245 million, respectively, which were classified as accounts payable.

At December 31, 2014 and 2013, approximately \$104 million and \$62 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries.

Also at December 31, 2014 and 2013, we had \$150 million and \$193 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, \$112 million and \$138 million, respectively, were included in accounts payable.

During the years ended December 31, 2014 and 2013, we entered into non-cancellable capital leases of approximately \$173 million and \$341 million, respectively, primarily for buildings and equipment.

***Investments in Debt and Equity Securities***

We classify investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2014 and 2013, we had no significant investments in securities classified as either

Table of Contents

held-to-maturity or trading. We carry securities classified as available-for-sale at fair value. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determine that a loss is other-than-temporary, at which point we would record a loss in our consolidated statements of operations. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

***Property and Equipment***

Additions and improvements to property and equipment exceeding established minimum amounts with a useful life greater than one year are capitalized at cost. Expenditures for maintenance and repairs are charged to expense as incurred. We use the straight-line method of depreciation for buildings, building improvements and equipment. The estimated useful life for buildings and improvements is primarily 15 to 40 years, and for equipment three to 15 years. Newly constructed hospitals are usually depreciated over 50 years. We record capital leases at the beginning of the lease term as assets and liabilities. The value recorded is the lower of either the present value of the minimum lease payments or the fair value of the asset. Such assets, including improvements, are generally amortized over the shorter of either the lease term or their estimated useful life. Interest costs related to construction projects are capitalized. In the years ended December 31, 2014, 2013 and 2012, capitalized interest was \$25 million, \$14 million and \$6 million, respectively.

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

***Goodwill and Other Intangible Assets***

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

Other intangible assets primarily consist of capitalized software costs, which are amortized on a straight-line basis over the estimated useful life of the software, which ranges from three to 15 years. Also included in intangible assets are costs associated with the issuance of our long-term debt, which are primarily being amortized under the effective interest method based on the terms of the specific notes, and miscellaneous intangible assets.

***Accruals for General and Professional Liability Risks***

We accrue for estimated professional and general liability claims, when they are probable and can be reasonably estimated. The accrual, which includes an estimate for incurred but not reported claims, is updated each quarter based on a model of projected payments using case-specific facts and circumstances and our historical loss

Table of Contents

reporting, development and settlement patterns and is discounted to its net present value using a risk-free discount rate (1.97% at December 31, 2014 and 2.45% at December 31, 2013). To the extent that subsequent claims information varies from our estimates, the liability is adjusted in the period such information becomes available. Malpractice expense is presented within other operating expenses in the accompanying Consolidated Statements of Operations.

**Income Taxes**

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;
- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

**Segment Reporting**

We primarily operate acute care hospitals and related healthcare facilities. Our general hospitals generated 88%, 90% and 95% of our net operating revenues before provision for doubtful accounts in the years ended December 31, 2014, 2013 and 2012, respectively. Each of our operating regions and markets reports directly to our president of hospital operations. Major decisions, including capital resource allocations, are made at the consolidated level, not at the regional, market or hospital level.

Historically, our business has consisted of one reportable segment, Hospital Operations and other. However, during 2012, our Hospital Operations and other segment and our Conifer subsidiary entered into formal agreements, pursuant to which it was agreed that services provided by both parties to each other would be billed based on estimated third-party pricing terms. As a result, we have presented Conifer as a separate reportable business segment for all periods

Table of Contents

presented. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

*Costs Associated With Exit or Disposal Activities*

We recognize costs associated with exit (including restructuring) or disposal activities when they are incurred and can be measured at fair value, rather than at the date of a commitment to an exit or disposal plan.

**NOTE 2. EQUITY***Reverse Stock Split*

On October 11, 2012, our common stock began trading on the New York Stock Exchange on a split-adjusted basis following a one-for-four reverse stock split we announced on October 1, 2012. Every four shares of our issued and outstanding common stock were exchanged for one issued and outstanding share of common stock, without any change in the par value per share, and our authorized shares of common stock were proportionately decreased from 1,050,000,000 shares to 262,500,000 shares. No fractional shares were issued in connection with the stock split. All amounts in the accompanying Consolidated Financial Statements and these notes related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for this reverse stock split.

*Share Repurchase Programs*

In October 2012, we announced that our board of directors had authorized the repurchase of up to \$500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase program, we paid approximately \$500 million to repurchase a total of 12,891,298 shares during the period from the commencement of the program through December 31, 2013.

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
<b>November 1, 2012 through December 31, 2012</b>	<b>3,406</b>	<b>\$ 29.36</b>	<b>3,406</b>	<b>\$ 400</b>
January 1, 2013 through January 31, 2013	531	37.13	531	380
February 1, 2013 through February 28, 2013	914	39.30	914	344
March 1, 2013 through March 31, 2013	1,010	43.95	1,010	300
<b>Three Months Ended March 31, 2013</b>	<b>2,455</b>	<b>40.74</b>	<b>2,455</b>	<b>300</b>
May 1, 2013 through May 31, 2013	933	46.78	933	256
June 1, 2013 through June 30, 2013	1,065	45.71	1,065	208
<b>Three Months Ended June 30, 2013</b>	<b>1,998</b>	<b>46.21</b>	<b>1,998</b>	<b>208</b>
July 1, 2013 through July 31, 2013	166	46.08	166	200
August 1, 2013 through August 31, 2013	1,045	40.43	1,045	158
September 1, 2013 through September 30, 2013	1,431	40.35	1,431	100
<b>Three Months Ended September 30, 2013</b>	<b>2,642</b>	<b>40.75</b>	<b>2,642</b>	<b>100</b>
November 1, 2013 through November 30, 2013	796	42.28	796	66
December 1, 2013 through December 31, 2013	1,594	41.62	1,594	—
<b>Three Months Ended December 31, 2013</b>	<b>2,390</b>	<b>41.84</b>	<b>2,390</b>	<b>—</b>
<b>Total</b>	<b>12,891</b>	<b>\$ 38.79</b>	<b>12,891</b>	<b>\$ —</b>

Repurchased shares are recorded based on settlement date and are held as treasury stock.

35

ATTACHMENT 6

Table of Contents

***Changes in Redeemable Noncontrolling Interests in Equity of Consolidated Subsidiaries***

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the year ended December 31, 2014 and 2013:

	<u>Year Ended December 31,</u>	
	<u>2014</u>	<u>2013</u>
<b>Balances at beginning of period</b>	<b>\$ 340</b>	<b>\$ 16</b>
Net income	33	9
Distributions paid to noncontrolling interests	(8)	(5)
Contributions from noncontrolling interests	11	—
Sales of joint venture interests	—	52
Purchases of businesses	25	268
<b>Balances at end of period</b>	<b>\$ 401</b>	<b>\$ 340</b>

As part of the acquisition of Vanguard, we obtained a 51% controlling interest in a limited liability company that held the assets and liabilities of Valley Baptist Health System (“Valley Baptist”), which consists of our hospitals in Brownsville and Harlingen, Texas. The remaining 49% non-controlling interest in the joint venture was held by the former owner of Valley Baptist (the “seller”). The joint venture operating agreement included a put option that would allow the seller to require us to purchase all or a portion of the seller’s remaining non-controlling interest in the limited liability company at certain specified time periods. In November 2014, the seller provided notice of its intent to exercise the put option for its entire 49% non-controlling interest, which is described in Note 22.

**NOTE 3. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS**

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

	<u>December 31,</u>	<u>December 31,</u>
	<u>2014</u>	<u>2013</u>
Continuing operations:		
Patient accounts receivable	\$ 3,178	\$ 2,459
Allowance for doubtful accounts	(851)	(589)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	125	92
Net cost reports and settlements payable and valuation allowances	(51)	(75)
	<u>2,401</u>	<u>1,887</u>
Discontinued Operations	3	3
<b>Accounts receivable, net</b>	<b>\$ 2,404</b>	<b>\$ 1,890</b>

At December 31, 2014 and 2013, our allowance for doubtful accounts was 26.8% and 24.0%, respectively, of our patient accounts receivable. The increase in the allowance for doubtful accounts as a percentage of patient accounts receivable related to the accounts receivable acquired from Vanguard as of October 1, 2013. Under the purchase price allocation rules, allowance for doubtful accounts as of the acquisition date are offset against the gross receivables. As of the acquisition date, the acquirer begins to disclose the net receivable amount with no disclosure of the former allowance for doubtful accounts amount. Accounts receivable generated after the acquisition are disclosed before the allowance for doubtful accounts and the associated allowance for doubtful accounts is also disclosed to arrive at net accounts receivable. The increase also related to the 120 basis point decrease in our self-pay collection rate for the 49 hospitals we operated throughout the years ended December 31, 2014 and 2013, as well as higher patient co-pays and deductibles, partially offset by a decline in uninsured revenues due to the expansion of insurance coverage under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

The increase in our total accounts receivable net of allowance for doubtful accounts from December 31, 2013 to December 31, 2014 is primarily related to the growth in hospital patient volumes, our outpatient development initiatives, a temporary buildup in accounts receivable of certain hospitals we acquired from Vanguard due to the implementation of



Table of Contents

a new billing system, growth in physician practices, the acquisition of Texas Regional Medical Center at Sunnyvale, Emanuel Medical Center and the opening of Resolute Health Hospital.

Accounts that are pursued for collection through Conifer’s regional business offices are maintained on our hospitals’ books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. At December 31, 2014 and 2013, our allowance for doubtful accounts for self-pay was 78.0% and 75.9%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. At December 31, 2014 and 2013, our allowance for doubtful accounts for managed care was 6.5% and 5.9%, respectively, of our managed care patient accounts receivable.

Accounts assigned to our Conifer subsidiary are written off and excluded from patient accounts receivable and allowance for doubtful accounts; however, an estimate of future recoveries from all accounts at our Conifer subsidiary is determined based on historical experience and recorded on our hospitals’ books as a component of accounts receivable in the accompanying Consolidated Balance Sheets. At the present time, our new acquisitions have not yet been fully integrated into our Conifer collections processes.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital’s eligibility for Medicaid disproportionate share hospital payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The table below shows our estimated costs for charity care patients and self-pay patients, as well as DSH payments we received, for the years ended December 31, 2014, 2013 and 2012.

	Years Ended December 31,		
	2014	2013	2012
Estimated costs for:			
Charity care patients	\$ 180	\$ 158	\$ 136
Self-pay patients	\$ 620	\$ 545	\$ 430
DSH payments received	\$ 817	\$ 428	\$ 283

As of December 31, 2014 and 2013, we had approximately \$399 million and \$64 million, respectively, of receivables recorded in other current assets and approximately \$212 million and \$32 million, respectively, of payables recorded in other current liabilities in the accompanying Consolidated Balance Sheets related to California’s provider fee program.

**NOTE 4. DISCONTINUED OPERATIONS**

Net operating revenues and loss before income taxes reported in discontinued operations are as follows:

	Years Ended December 31,		
	2014	2013	2012
Net operating revenues	\$ 4	\$ 7	\$ 154
Net loss before income taxes	(35)	(7)	(101)

Net loss before income taxes from discontinued operations in the year ended December 31, 2014 included approximately \$18 million of expense recorded in litigation and investigation costs allocable to one of our previously

38

39

ATTACHMENT 6

Table of Contents

divested hospitals related to a class action lawsuit discussed in Note 15. In the year ended December 31, 2013, we recognized a \$12 million gain in discontinued operations related to the sale of land.

In the three months ended June 30, 2012, our Creighton University Medical Center hospital ("CUMC") in Nebraska was reclassified into discontinued operations based on the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," as a result of our plan to sell CUMC. We recorded an impairment charge in discontinued operations of \$100 million, consisting of \$98 million for the write-down of CUMC's long-lived assets to their estimated fair values, less estimated costs to sell, and a \$2 million charge for the write-down of goodwill related to CUMC in the three months ended June 30, 2012. We completed the sale of CUMC on August 31, 2012 at a transaction price of \$40 million, excluding working capital, and recognized a loss on sale of approximately \$1 million in discontinued operations.

In May 2012, we completed the sale of Diagnostic Imaging Services, Inc. ("DIS"), our former diagnostic imaging center business in Louisiana, for net proceeds of approximately \$10 million. As a result of the sale, DIS was reclassified into discontinued operations in the three months ended June 30, 2012, and a gain on sale of approximately \$2 million was recognized in discontinued operations.

Should we dispose of additional hospitals or other assets in the future, we may incur additional asset impairment and restructuring charges in future periods.

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

We recognized impairment charges on long-lived assets in 2014, 2013 and 2012 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in healthcare industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

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

As of December 31, 2014, our continuing operations consisted of two reportable segments, our Hospital Operations and other and Conifer. During the three months ended March 31, 2014, we combined our California region and our Phoenix market to form our Western region. Our Hospital Operations and other segment is currently structured as follows:

- Our Central region includes all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the Resolute Health, San Antonio and South Texas markets;
- Our Florida region includes all of our hospitals and other operations in Florida;
- Our Northeast region includes all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region includes all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;

Table of Contents

- Our Western region includes all of our hospitals and other operations in Arizona and California;
- Our Detroit market includes all of our hospitals and other operations in the Detroit, Michigan area;
- Our Resolute Health market includes our hospital and other operations in the New Braunfels, Texas area;
- Our San Antonio market includes all of our hospitals and other operations in the San Antonio, Texas area; and
- Our South Texas market includes all of our hospitals and other operations in the Brownsville and Harlingen, Texas areas.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

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

*Year Ended December 31, 2014*

During the year ended December 31, 2014, we recorded impairment and restructuring charges and acquisition-related costs of \$153 million. This amount included a \$20 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment declines. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was \$23 million as of December 31, 2014 after recording the impairment charge. We also recorded \$16 million of employee severance costs, \$19 million of contract and lease termination fees, \$3 million of restructuring costs, and \$95 million in acquisition-related costs, which include \$16 million of transaction costs and \$79 million of acquisition integration charges.

*Year Ended December 31, 2013*

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of \$103 million. This amount included a \$12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors

Table of Contents

contributing to the adverse financial trends at that time included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. We disclosed in our Annual Report on Form 10-K for the year ended December 31, 2013 that, unless the anticipated future financial trends of this hospital improved to the extent that the estimated future undiscounted cash flows exceeded the carrying value of the long-lived assets, this hospital was at risk of future impairments, which impairments occurred in 2014 as described above, particularly if we spent significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment declined. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was \$44 million as of December 31, 2013 after recording the impairment charge. We also recorded \$16 million of restructuring costs, \$14 million of employee severance costs, \$2 million of lease termination fees, and \$59 million in acquisition-related costs, which included both transaction costs and acquisition integration charges.

*Year Ended December 31, 2012*

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of \$19 million, consisting of \$3 million relating to the impairment of obsolete assets, \$2 million relating to other impairment charges, \$8 million of employee severance costs and \$6 million of other related costs.

**NOTE 6. LONG-TERM DEBT AND LEASE OBLIGATIONS**

The table below shows our long-term debt as of December 31, 2014 and 2013:

	<u>December 31,</u> <u>2014</u>	<u>December 31,</u> <u>2013</u>
<b>Senior notes:</b>		
9 <sup>7</sup> / <sub>8</sub> %, due 2014	\$ —	\$ 60
9 <sup>1</sup> / <sub>4</sub> %, due 2015	—	474
5%, due 2019	1,100	—
5 <sup>1</sup> / <sub>2</sub> %, due 2019	500	—
6 <sup>3</sup> / <sub>4</sub> %, due 2020	300	300
8%, due 2020	750	750
8 <sup>1</sup> / <sub>8</sub> %, due 2022	2,800	2,800
6 <sup>7</sup> / <sub>8</sub> %, due 2031	430	430
<b>Senior secured notes:</b>		
6 <sup>1</sup> / <sub>4</sub> %, due 2018	1,041	1,041
4 <sup>3</sup> / <sub>4</sub> %, due 2020	500	500
6%, due 2020	1,800	1,800
4 <sup>1</sup> / <sub>2</sub> %, due 2021	850	850
4 <sup>3</sup> / <sub>8</sub> %, due 2021	1,050	1,050
Credit facility due 2016	220	405
Capital leases and mortgage notes	487	417
Unamortized note discounts and premium	(21)	(28)
<b>Total long-term debt</b>	<u>11,807</u>	<u>10,849</u>
Less current portion	112	153
<b>Long-term debt, net of current portion</b>	<u>\$ 11,695</u>	<u>\$ 10,696</u>

**Credit Agreement**

We have a senior secured revolving credit facility (as amended, "Credit Agreement") that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to \$1 billion, with a \$300 million

42

43

ATTACHMENT 6

Table of Contents

subfacility for standby letters of credit. The Credit Agreement, which has a scheduled maturity date of November 29, 2016, is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. In addition, borrowings under the Credit Agreement are guaranteed by our wholly owned hospital subsidiaries. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 1.00% to 1.50% or the London Interbank Offered Rate plus a margin ranging from 2.00% to 2.50% per annum based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.375% to 0.500% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At December 31, 2014, we had \$220 million of cash borrowings outstanding under the revolving credit facility subject to an interest rate of 2.38%, and we had approximately \$4 million of standby letters of credit outstanding. Based on our eligible receivables, approximately \$776 million was available for borrowing under the revolving credit facility at December 31, 2014.

**Letter of Credit Facility**

On March 7, 2014, we entered into a new letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our existing Credit Agreement, which we transferred to the LC Facility (the "Existing Letters of Credit")), from time to time, in an aggregate principal amount of up to \$180 million (subject to increase to up to \$200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes.

Drawings under any letter of credit issued under the LC Facility (including the Existing Letters of Credit) that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.875% per annum. An unused commitment fee is payable at an initial rate of 0.50% per annum with a step down to 0.375% per annum based on the secured debt to EBITDA ratio of 3.00 to 1.00. A per annum fee on the aggregate outstanding amount of issued but undrawn letters of credit (including Existing Letters of Credit) will accrue at a rate of 1.875% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At December 31, 2014, we had approximately \$115 million of standby letters of credit outstanding under the LC Facility.

**Senior Notes and Senior Secured Notes**

In September 2014, we sold \$500 million aggregate principal amount of 5 $\frac{1}{2}$ % senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, commencing on March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

In June and March 2014, we sold \$500 million and \$600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 9 $\frac{1}{4}$ % senior notes due 2015 in July 2014. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately \$24 million, primarily related to the difference between the redemption price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs. The net proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement.

In October 2013, we sold \$2.8 billion aggregate principal amount of 8 $\frac{1}{8}$ % senior notes, which will mature on April 1, 2022, and \$1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8 $\frac{1}{8}$ % senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard.

Table of Contents

In May 2013, we sold \$1.050 billion aggregate principal amount of 4<sup>3</sup>/<sub>8</sub>% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4<sup>3</sup>/<sub>8</sub>% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, commencing on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately \$767 million aggregate principal amount outstanding of our 8<sup>7</sup>/<sub>8</sub>% senior secured notes due 2019 in a tender offer and to call approximately \$158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of \$171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold \$850 million aggregate principal amount of 4<sup>1</sup>/<sub>2</sub>% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4<sup>1</sup>/<sub>2</sub>% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately \$645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately \$69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of \$177 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs. The remaining net proceeds were used for general corporate purposes, including the repayment of borrowings under our senior secured revolving credit facility.

In October 2012, we sold \$500 million aggregate principal amount of 4<sup>3</sup>/<sub>4</sub>% senior secured notes due 2020 and \$300 million aggregate principal amount of 6<sup>3</sup>/<sub>4</sub>% senior notes due 2020. The 4<sup>3</sup>/<sub>4</sub>% senior secured notes will mature on June 1, 2020, and the 6<sup>3</sup>/<sub>4</sub>% senior notes will mature on February 1, 2020. We will pay interest on the 4<sup>3</sup>/<sub>4</sub>% senior secured notes semi-annually in arrears on June 1 and December 1 of each year, commencing on June 1, 2013. We will pay interest on the 6<sup>3</sup>/<sub>4</sub>% senior notes semi-annually in arrears on February 1 and August 1 of each year; payments commenced on February 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase \$161 million aggregate principal amount outstanding of our 7<sup>3</sup>/<sub>8</sub>% senior notes due 2013 in a tender offer. In connection with the purchase, we recorded a loss from early extinguishment of debt of approximately \$4 million primarily related to the difference between the purchase prices and the par values of the purchased notes.

In April 2012, we issued an additional \$141 million aggregate principal amount of our 6<sup>1</sup>/<sub>4</sub>% senior secured notes due 2018 at a premium for \$142 million of cash proceeds and an additional \$150 million aggregate principal amount of our 8% senior notes due 2020 in a private financing related to our repurchase and subsequent retirement of 298,700 shares of our 7% mandatory convertible preferred stock.

All of our senior notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to our senior secured notes described below, the obligations of our subsidiaries and any obligations under our Credit Agreement to the extent of the collateral. We may redeem any series of our senior notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed, plus a make-whole premium specified in the applicable indenture, together with accrued and unpaid interest to the redemption date.

All of our senior secured notes are guaranteed by certain of our hospital company subsidiaries and secured by a first-priority pledge of the capital stock and other ownership interests of those subsidiaries. All of our senior secured notes and the related subsidiary guarantees are our and the subsidiary guarantors' senior secured obligations. All of our senior secured notes rank equally in right of payment with all of our other senior secured indebtedness. Our senior secured notes rank senior to any subordinated indebtedness that we or such subsidiary guarantors may incur; they are effectively senior to our and such subsidiary guarantors' existing and future unsecured indebtedness and other liabilities to the extent of the value of the collateral securing the notes and the subsidiary guarantees; they are effectively subordinated to our and such subsidiary guarantors' obligations under our Credit Agreement to the extent of the value of the collateral securing borrowings thereunder; and they are structurally subordinated to all obligations of our non-guarantor subsidiaries.

The indentures setting forth the terms of our senior secured notes contain provisions governing our ability to redeem the notes and the terms by which we may do so. At our option, we may redeem our senior secured notes, in

Table of Contents

whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed plus the make-whole premium set forth in the related indenture, together with accrued and unpaid interest thereon, if any, to the redemption date.

In addition, we may be required to purchase for cash all or any part of each series of our senior secured notes upon the occurrence of a change of control (as defined in the applicable indentures) for a cash purchase price of 101% of the aggregate principal amount of the notes, plus accrued and unpaid interest.

Covenants

Our Credit Agreement contains customary covenants for an asset-backed facility, including a minimum fixed charge coverage ratio to be met when the available credit under the revolving credit facility falls below \$80 million, as well as limits on debt, asset sales and prepayments of senior debt. The Credit Agreement also includes a provision, which we believe is customary in receivables-backed credit facilities, that gives our banks the right to require that proceeds of collections of substantially all of our consolidated accounts receivable be applied directly to repay outstanding loans and other amounts that are due and payable under the Credit Agreement at any time that unused borrowing availability under the revolving credit facility is less than \$100 million or if an event of default has occurred and is continuing thereunder. In that event, we would seek to re-borrow under the Credit Agreement to satisfy our operating cash requirements. Our ability to borrow under the Credit Agreement is subject to conditions that we believe are customary in revolving credit facilities, including that no events of default then exist.

The indentures governing our senior notes contain covenants and conditions that have, among other requirements, limitations on (1) liens on principal properties and (2) sale and lease-back transactions with respect to principal properties. A principal property is defined in the indentures as a hospital that has an asset value on our books in excess of 5% of our consolidated net tangible assets, as defined. The above limitations do not apply, however, to (1) debt that is not secured by principal properties or (2) debt that is secured by principal properties if the aggregate of such secured debt does not exceed 15% of our consolidated net tangible assets, as further described in the indentures. The indentures also prohibit the consolidation, merger or sale of all or substantially all assets unless no event of default would result after giving effect to such transaction.

The indentures governing our senior secured notes contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions or consolidate, merge or sell all or substantially all of our or their assets, other than in certain transactions between one or more of our wholly owned subsidiaries. These restrictions, however, are subject to a number of important exceptions and qualifications. In particular, there are no restrictions on our ability or the ability of our subsidiaries to incur additional indebtedness, make restricted payments, pay dividends or make distributions in respect of capital stock, purchase or redeem capital stock, enter into transactions with affiliates or make advances to, or invest in, other entities (including unaffiliated entities). In addition, the indentures governing our senior secured notes contain a covenant that neither we nor any of our subsidiaries will incur secured debt, unless at the time of and after giving effect to the incurrence of such debt, the aggregate amount of all such secured debt (including the aggregate principal amount of senior secured notes outstanding at such time) does not exceed the greater of (i) \$3.2 billion or (ii) the amount that would cause the secured debt ratio (as defined in the indentures) to exceed 4.0 to 1.0; provided that the aggregate amount of all such debt secured by a lien on par to the lien securing the senior secured notes may not exceed the greater of (a) \$2.6 billion or (b) the amount that would cause the secured debt ratio to exceed 3.0 to 1.0.

Table of Contents  
Future Maturities

Future long-term debt maturities and minimum operating lease payments as of December 31, 2014 are as follows:

	Total	Years Ending December 31,					Later Years
		2015	2016	2017	2018	2019	
Long-term debt, including capital lease obligations	\$ 11,828	\$ 112	\$ 259	\$ 53	\$ 1,103	\$ 1,611	\$ 8,690
Long-term non-cancelable operating leases	\$ 907	\$ 156	\$ 140	\$ 120	\$ 96	\$ 79	\$ 316

Rental expense under operating leases, including short-term leases, was \$242 million, \$186 million and \$156 million in the years ended December 31, 2014, 2013 and 2012, respectively. Included in rental expense for each of these periods was sublease income of \$9 million, \$8 million and \$8 million, respectively, which were recorded as a reduction to rental expense.

**NOTE 7. GUARANTEES**

Consistent with our policy on physician relocation and recruitment, we provide income guarantee agreements to certain physicians who agree to relocate to fill a community need in the service area of one of our hospitals and commit to remain in practice in the area for a specified period of time. Under such agreements, we are required to make payments to the physicians in excess of the amounts they earn in their practices up to the amount of the income guarantee. The income guarantee periods are typically 12 months. If a physician does not fulfill his or her commitment period to the community, which is typically three years subsequent to the guarantee period, we seek recovery of the income guarantee payments from the physician on a prorated basis. We also provide revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals with terms generally ranging from one to three years.

At December 31, 2014, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was \$97 million. We had a liability of \$76 million recorded for these guarantees included in other current liabilities at December 31, 2014.

**NOTE 8. EMPLOYEE BENEFIT PLANS**

*Share-Based Compensation Plans*

We currently grant stock-based awards to our directors and key employees pursuant to our 2008 Stock Incentive Plan, which was approved by our shareholders at their 2008 annual meeting. At December 31, 2014, approximately 5.3 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, from time to time, we grant performance-based options and restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe.

Our income from continuing operations for the years ended December 31, 2014, 2013 and 2012 includes \$51 million, \$39 million and \$33 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements (\$32 million, \$24 million and \$21 million, respectively, after-tax). The table below shows certain stock option and restricted stock unit grants and other awards that comprise the \$51 million of stock-based compensation expense recorded in salaries, wages and benefits in the year ended December 31, 2014. Compensation cost is measured by the fair value of the awards on their grant dates and is recognized over the requisite service period of the awards, whether or not the awards had any intrinsic value during the period.

Table of Contents

Grant Date	Awards (In Thousands)	Exercise Price Per Share	Fair Value Per Share at Grant Date	Stock-Based
				Compensation Expense for Year Ended December 31, 2014 (In Millions)
<b>Stock Options:</b>				
February 28, 2013	278	\$ 39.31	\$ 14.46	\$ 1
February 29, 2012	356	\$ 22.60	11.96	2
<b>Restricted Stock Units:</b>				
August 25, 2014	394		59.90	2
May 9, 2014	32		44.36 <sup>(1)</sup>	1
February 26, 2014	1,291		44.12	17
June 13, 2013	318		47.13	3
February 28, 2013	883		39.31	12
February 29, 2012	946		22.60	7
Other grants				6
				<b>\$ 51</b>

(1) End of month fair market value was used for this grant to calculate compensation expense.

Prior to our shareholders approving the 2008 Stock Incentive Plan, we granted stock-based awards to our directors and employees pursuant to other plans. Stock options remain outstanding under those other plans, but no additional stock-based awards will be granted under them.

Pursuant to the terms of our stock-based compensation plans, awards granted under the plans vest and may be exercised as determined by the compensation committee of our board of directors. In the event of a change in control, the compensation committee may, at its sole discretion without obtaining shareholder approval, accelerate the vesting or performance periods of the awards.

**Stock Options**

The following table summarizes stock option activity during the years ended December 31, 2014, 2013 and 2012:

Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average	
			Remaining Life	
Outstanding as of December 31, 2011	8,498,393	25.04		
Granted	477,500	22.79		
Exercised	(3,657,127)	5.77		
Forfeited/Expired	(1,029,574)	69.72		
Outstanding as of December 31, 2012	4,289,192	30.49		
Granted	295,639	39.41		
Exercised	(946,086)	23.34		
Forfeited/Expired	(330,634)	55.79		
Outstanding as of December 31, 2013	3,308,111	\$ 30.79		
Granted	—			
Exercised	(699,910)	33.53		
Forfeited/Expired	(624,052)	47.97		
<b>Outstanding as of December 31, 2014</b>	<b>1,984,149</b>	<b>\$ 24.42</b>	<b>\$ 52</b>	<b>3.7 years</b>
<b>Vested and expected to vest at December 31, 2014</b>	<b>1,907,464</b>	<b>\$ 24.35</b>	<b>\$ 50</b>	<b>3.6 years</b>
<b>Exercisable as of December 31, 2014</b>	<b>1,579,018</b>	<b>\$ 21.92</b>	<b>\$ 45</b>	<b>3.5 years</b>

ATTACHMENT 6

48

49

ATTACHMENT 6

Table of Contents

There were 699,910 stock options exercised during the year ended December 31, 2014 with a \$13 million aggregate intrinsic value, and 946,086 stock options exercised in 2013 with a \$18 million aggregate intrinsic value.

As of December 31, 2014, there were \$2 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of one year.

In the year ended December 31, 2014, there were no stock options granted. In the year ended December 31, 2013, we granted an aggregate of 295,639 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. These stock options will all vest on the third anniversary of the grant date, subject to the terms of the Plan, and will expire on the fifth anniversary of the grant date.

The weighted average estimated fair value of stock options we granted in the year ended December 31, 2013 was \$14.46 per share. These fair values were calculated based on each grant date, using a binomial lattice model with the following assumptions:

	<u>Year Ended December 31, 2013</u>
Expected volatility	50%
Expected dividend yield	0%
Expected life	3.6 years
Expected forfeiture rate	6%
Risk-free interest rate	0.48%
Early exercise threshold	100% gain
Early exercise rate	50% per year

The expected volatility used in the binomial lattice model incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price on two dates (one in 2010 and one in 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from the output of the binomial lattice model and represents the period of time that the options are expected to be outstanding. This model incorporates an early exercise assumption in the event of a significant increase in stock price. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise timeframes.

The following table summarizes information about our outstanding stock options at December 31, 2014:

	<u>Options Outstanding</u>			<u>Options Exercisable</u>	
		Weighted Average			Weighted Average
<u>Range of Exercise Prices</u>	<u>Number of Options</u>	<u>Remaining Contractual Life</u>	<u>Weighted Average Exercise Price</u>	<u>Number of Options</u>	<u>Weighted Average Exercise Price</u>
\$0.00 to \$4.569	237,303	4.2 years	\$ 4.56	237,303	\$ 4.56
\$4.57 to \$25.089	957,583	5.0 years	20.96	830,903	20.67
\$25.09 to \$32.569	402,816	1.6 years	29.32	402,816	29.32
\$32.57 to \$42.089	386,447	2.3 years	40.08	107,996	42.08
	<u>1,984,149</u>	<u>3.7 years</u>	<u>\$ 24.42</u>	<u>1,579,018</u>	<u>\$ 21.92</u>

As of December 31, 2014, all of our outstanding options were in-the-money, that is, they had exercise price less than the \$50.67 market price of our common stock on December 31, 2014.

Table of Contents  
Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2014, 2013 and 2012:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested as of December 31, 2011	1,927,307	\$ 24.52
Granted	1,654,337	22.18
Vested	(1,033,632)	23.51
Forfeited	<u>(252,070)</u>	23.39
Unvested as of December 31, 2012	2,295,942	23.40
Granted	1,564,224	41.20
Vested	(966,838)	24.20
Forfeited	<u>(186,106)</u>	29.69
Unvested as of December 31, 2013	2,707,222	33.34
Granted	1,772,276	48.42
Vested	(1,009,927)	27.49
Forfeited	<u>(169,851)</u>	36.64
<b>Unvested as of December 31, 2014</b>	<b><u>3,299,720</u></b>	<b>\$ 40.99</b>

In the year ended December 31, 2014, we granted 1,046,910 restricted stock units subject to time-vesting of which 945,409 will vest and be settled ratably over a three-year period from the date of the grant, 23,435 will vest 100% on the tenth anniversary of the grant date, 63,623 will vest 100% on the fifth anniversary of the grant date and 14,443 will vest 100% on the third anniversary of the grant date. In addition, our newly appointed Board of Director member received an initial grant of 1,240 restricted stock units that immediately vested but will not settle until her separation from the board and an annual grant of 1,368 restricted stock units that immediately vested but will not settle until the earlier of three years or her separation from the board. Also, we granted 271,815 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of a specified one-year performance goal for the year ended December 31, 2014, which performance goal was achieved. The performance-based restricted stock units will vest ratably over a three-year period from the grant date. If the performance goal had not been achieved, the restricted stock units would have been forfeited. The actual number of performance-based restricted stock units that could have vested ranged from 0% to 200% of the 271,815 units granted, depending on our level of achievement with respect to the performance goal. We also granted 450,943 special retention restricted stock units to a select group of officers; two-thirds of the award will vest contingent on our achievement of a performance goal of which one-half will vest based on performance over a one-year period ending in December 2015 and the remaining one-half will vest based on performance over a four-year period ending in December 2018. The remaining one-third of this special retention award will vest in full on the fifth anniversary of the grant date.

In the year ended December 31, 2013, we granted 1,122,811 restricted stock units subject to time-vesting, of which 1,023,112 will vest and be settled ratably over a three-year period from the grant date and 80,133 will vest 100% on the fifth anniversary of the grant date and 19,566 will vest 100% on the third anniversary of the grant date. In addition, we granted 206,058 performance-based restricted stock units to certain of our senior officers. Because the performance goal for the year ended December 31, 2013 was met at the target level, 100% of the performance-based restricted stock units will vest and be settled ratably over a three-year period from the grant date. We also awarded a grant of 23,175 performance-based restricted stock units to one of our senior executives. If target conditions are met, 100% of this grant will vest and be settled three years from the grant date. We also awarded a grant of 212,180 restricted stock units to our chief executive officer, of which 106,090 are subject to time-vesting and 106,090 are performance-based. If target conditions are met, 50% of this grant will vest three years from the grant date and the remaining 50% will vest six years from the grant date. The award also allows for an additional 106,090 shares to be issued if higher performance criteria are met.

As of December 31, 2014, there were \$99 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.8 years.

Table of Contents

***Employee Stock Purchase Plan***

We have an employee stock purchase plan under which we are currently authorized to issue up to 5,062,500 shares of common stock to our eligible employees. As of December 31, 2014, there were approximately 258,875 shares available for issuance under our employee stock purchase plan. Under the terms of the plan, eligible employees may elect to have between 1% and 10% of their base earnings withheld each quarter to purchase shares of our common stock. Shares are purchased at a price equal to 95% of the closing price on the last day of the quarter. The plan requires a one-year holding period for all shares issued. The holding period does not apply upon termination of employment. Under the plan, no individual may purchase, in any year, shares with a fair market value in excess of \$25,000. The plan is currently not considered to be compensatory.

We sold the following numbers of shares under our employee stock purchase plan in the years ended December 31, 2014, 2013 and 2012:

	Years Ended December 31,		
	2014	2013	2012
Number of shares	162,128	100,217	144,021
Weighted average price	\$ 46.91	\$ 42.88	\$ 22.81

***Employee Retirement Plans***

Substantially all of our employees, upon qualification, are eligible to participate in one of our defined contribution 401(k) plans. Under the plans, employees may contribute a portion of their eligible compensation, and we match such contributions annually up to a maximum percentage for participants actively employed, as defined by the plan documents. Employer matching contributions will vary by plan. Plan expenses, primarily related to our contributions to the plan, were approximately \$92 million, \$35 million and \$32 million for the years ended December 31, 2014, 2013 and 2012, respectively. Such amounts are reflected in salaries, wages and benefits in the accompanying Consolidated Statements of Operations.

We maintain three frozen non-qualified defined benefit pension plans ("SERPs") that provide supplemental retirement benefits to certain of our current and former executives. One of these SERPs was frozen during the year ended December 31, 2014. These plans are not funded, and plan obligations for these plans are paid from our working capital. Pension benefits are generally based on years of service and compensation. Upon completing the acquisition of Vanguard on October 1, 2013, we assumed a frozen qualified defined benefit plan ("DMC Pension Plan") covering substantially all of the employees of our Detroit market that were hired prior to June 1, 2003. The benefits paid under the DMC Pension Plan are primarily based on years of service and final average earnings. During the year ended December 31, 2014, the Society of Actuaries issued new mortality tables (RP-2014) and a mortality improvement scale (MP-2014), which we have incorporated into the estimates of our defined benefit plan obligations as of December 31, 2014. These changes to our mortality assumptions increased our projected benefit obligations by

## Table of Contents

approximately \$87 million. The following tables summarize the balance sheet impact, as well as the benefit obligations, funded status and rate assumptions associated with the SERPs and the DMC Pension Plan based on actuarial valuations prepared as of December 31, 2014 and 2013:

	December 31,	
	2014	2013
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations <sup>(1)</sup>		
Beginning obligations	\$ (1,303)	\$ (312)
Assumed from acquisition	—	(1,037)
Service cost	(3)	(2)
Interest cost	(66)	(25)
Actuarial gain(loss)	(268)	44
Plan changes	—	(2)
Benefits paid/employer contributions	81	31
Ending obligations	(1,559)	(1,303)
Fair value of plans assets		
Beginning obligations	886	—
Assumed from acquisition	—	863
Gain on plan assets	70	34
Employer contribution	3	—
Benefits paid	(61)	(11)
Ending plan assets	898	886
Funded status of plans	<u>\$ (661)</u>	<u>\$ (417)</u>
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	\$ (28)	\$ (19)
Other long-term liability	(633)	(398)
Accumulated other comprehensive loss	276	22
	<u>\$ (385)</u>	<u>\$ (395)</u>
SERP Assumptions:		
Discount rate	4.25 %	5.00 %
Compensation increase rate	3.00 %	3.00 %
Measurement date	December 31, 2014	December 31, 2013
DMC Pension Plan Assumptions:		
Discount rate	4.16 %	5.18
Compensation increase rate	Frozen	Frozen
Measurement date	December 31, 2014	December 31, 2013

(1) The accumulated benefit obligation at December 31, 2014 and 2013 was approximately \$1.544 billion and \$1.297 billion, respectively.

Table of Contents

The components of net periodic benefit costs and related assumptions are as follows:

	Years Ended December 31,		
	2014	2013	2012
Service costs	\$ 3	\$ 2	\$ 2
Interest costs	66	25	14
Expected return on plan assets	(60)	(15)	—
Amortization of prior-year service costs	—	—	—
Amortization of net actuarial loss	4	7	5
<b>Net periodic benefit cost</b>	<b>\$ 13</b>	<b>\$ 19</b>	<b>\$ 21</b>
<b>SERP Assumptions:</b>			
Discount rate	5.00 %	4.00 %	5.00 %
Long-term rate of return on assets	n/a	n/a	n/a
Compensation increase rate	3.00 %	3.00 %	3.00 %
Measurement date	January 1, 2014	January 1, 2013	January 1, 2012
Census date	January 1, 2014	January 1, 2013	January 1, 2012
<b>DMC Pension Plan Assumptions:</b>			
Discount rate	5.18 %	5.01 %	n/a
Long-term rate of return on assets	7.00 %	7.00 %	n/a
Compensation increase rate	Frozen	Frozen	n/a
Measurement date	January 1, 2014	October 1, 2013	n/a
Census date	January 1, 2014	January 1, 2013	n/a

Net periodic benefit costs for the current year are based on assumptions determined at the valuation date of the prior year for the SERPs and the DMC Pension Plan.

We recorded gain/(loss) adjustments of (\$254) million, \$69 million and (\$25) million in other comprehensive income (loss) in the years ended December 31, 2014, 2013 and 2012, respectively, to recognize changes in the funded status of our SERPs and the DMC Pension Plan. Changes in the funded status are recorded as a direct increase or decrease to shareholders' equity through accumulated other comprehensive loss. Net actuarial gains/(losses) of (\$258) million, \$63 million and (\$30) million during the years ended December 31, 2014, 2013 and 2012, respectively, and the amortization of net actuarial loss of \$4 million, \$7 million and \$5 million for the years ended December 31, 2014, 2013 and 2012, respectively, were recognized in other comprehensive income (loss). Cumulative net actuarial losses of \$276 million, \$22 million and \$90 million as of December 31, 2014, 2013 and 2012, respectively, and unrecognized prior service costs of less than \$1 million as of each of the years ended December 31, 2014, 2013 and 2012, have not yet been recognized as components of net periodic benefit costs.

To develop the expected long-term rate of return on plan assets assumption, the DMC Pension Plan considers the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns on each asset class. The expected return for each asset class is then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. The weighted-average asset allocations by asset category as of December 31, 2014, were as follows:

<u>Asset Category</u>	<u>Target</u>	<u>Actual</u>
Cash and cash equivalents	6 %	6 %
United States government obligations	1 %	1 %
Equity securities	50 %	50 %
Debt Securities	43 %	43 %

The DMC Pension Plan assets are invested in separately managed portfolios using investment management firms. The objective for all asset categories is to maximize total return without assuming undue risk exposure. The DMC Pension Plan maintains a well-diversified asset allocation that best meets these objectives. The DMC Pension Plan assets

54

Table of Contents

are largely comprised of equity securities, which include companies with various market capitalization sizes in addition to international and convertible securities. Cash and cash equivalents are comprised of money market funds. Debt securities include domestic and foreign government obligations, corporate bonds, and mortgage-backed securities. Under the investment policy of the DMC Pension Plan, investments in derivative securities are not permitted for the sole purpose of speculating on the direction of market interest rates. Included in this prohibition are leveraging, shorting, swaps, futures, options, forwards, and similar strategies.

In each investment account, the DMC Pension Plan investment managers are responsible to monitor and react to economic indicators, such as gross domestic product, consumer price index and U.S. monetary policy that may affect the performance of their account. The performance of all managers and the aggregate asset allocation are formally reviewed on a quarterly basis, with a rebalancing of the asset allocation occurring at least once a year. The current asset allocation objective is to maintain a certain percentage with each class allowing for a 10% deviation from the target.

The following tables summarize the DMC Pension Plan assets measured at fair value on a recurring basis as of December 31, 2014, aggregated by the level in the fair value hierarchy within which those measurements are determined. Fair value methodologies for Level 1, Level 2 and Level 3 are consistent with the inputs described in Note 18.

	<u>December 31, 2014</u>	<u>(Level 1)</u>	<u>(Level 2)</u>	<u>(Level 3)</u>
Cash and cash equivalents	\$ 55	\$ 55	\$ —	\$ —
United States government obligations	5	5	—	—
Corporate bonds	391	391	—	—
Equity securities	447	447	—	—
	<u>\$ 898</u>	<u>\$ 898</u>	<u>\$ —</u>	<u>\$ —</u>

The following table presents the estimated future benefit payments to be made from the SERPs and the DMC Pension Plan, a portion of which will be funded from plan assets, for the next five years and in the aggregate for the five years thereafter:

	<u>Total</u>	<u>Years Ending December 31, 2014</u>					<u>Five Years Thereafter</u>
		<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	
Estimated benefit payments	\$ 896	\$ 84	\$ 80	\$ 83	\$ 86	\$ 89	\$ 474

The SERP and DMC Pension Plan obligations of \$661 million at December 31, 2014 are classified in the accompanying Consolidated Balance Sheet as an other current liability (\$28 million) and defined benefit plan obligations (\$633 million) based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately \$28 million for the year ending December 31, 2015.

**NOTE 9. CAPITAL COMMITMENTS**

In connection with Vanguard's acquisition of Detroit Medical Center, certain capital commitments were agreed to be satisfied at particular dates. If these commitments are not met by these required dates, we are required to escrow cash for the purpose of funding certain capital projects. There was no required escrow balance as of December 31, 2014.

55

Table of Contents

**NOTE 10. PROPERTY AND EQUIPMENT**

The principal components of property and equipment are shown in the table below:

	December 31,	
	2014	2013
Land	\$ 650	\$ 660
Buildings and improvements	7,013	6,166
Construction in progress	161	593
Equipment	<u>4,387</u>	<u>4,070</u>
	12,211	11,489
Accumulated depreciation and amortization	<u>(4,478)</u>	<u>(3,907)</u>
<b>Net property and equipment</b>	<b><u>\$ 7,733</u></b>	<b><u>\$ 7,582</u></b>

Property and equipment is stated at cost, less accumulated depreciation and amortization and impairment write-downs related to assets held and used.

**NOTE 11. GOODWILL AND OTHER INTANGIBLE ASSETS**

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying Consolidated Balance Sheets as of December 31, 2014 and 2013:

	2014	2013
<b>Hospital Operations and other</b>		
As of January 1:		
Goodwill	\$ 5,584	\$ 3,268
Accumulated impairment losses	<u>(2,430)</u>	<u>(2,430)</u>
Total	3,154	838
Goodwill acquired during the year and purchase price allocation adjustments	153	2,316
Goodwill allocated to hospital sold	—	—
Impairment of goodwill	—	—
<b>Total</b>	<b><u>\$ 3,307</u></b>	<b><u>\$ 3,154</u></b>
As of December 31:		
Goodwill	\$ 5,737	\$ 5,584
Accumulated impairment losses	<u>(2,430)</u>	<u>(2,430)</u>
<b>Total</b>	<b><u>\$ 3,307</u></b>	<b><u>\$ 3,154</u></b>
<b>Conifer</b>		
As of January 1:		
Goodwill	\$ 412	\$ 78
Accumulated impairment losses	—	—
Total	412	78
Goodwill acquired during the year and purchase price allocation adjustments	194	334
<b>Total</b>	<b><u>\$ 606</u></b>	<b><u>\$ 412</u></b>
As of December 31:		
Goodwill	\$ 606	\$ 412
Accumulated impairment losses	—	—
<b>Total</b>	<b><u>\$ 606</u></b>	<b><u>\$ 412</u></b>

Table of Contents

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of December 31, 2014 and 2013:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2014:			
Capitalized software costs	\$ 1,412	\$ (586)	\$ 826
Long-term debt issuance costs	245	(49)	196
Trade names	106	—	106
Contracts	57	(6)	51
Other	129	(30)	99
<b>Total</b>	<b>\$ 1,949</b>	<b>\$ (671)</b>	<b>\$ 1,278</b>
As of December 31, 2013:			
Capitalized software costs	\$ 1,148	\$ (468)	\$ 680
Long-term debt issuance costs	230	(31)	199
Trade Names	106	—	106
Contracts	57	(2)	55
Other	80	(15)	65
<b>Total</b>	<b>\$ 1,621</b>	<b>\$ (516)</b>	<b>\$ 1,105</b>

Estimated future amortization of intangibles with finite useful lives as of December 31, 2014 is as follows:

	Total	Years Ending December 31,					Later Years
		2015	2016	2017	2018	2019	
Amortization of intangible assets	\$ 1,166	\$ 218	\$ 208	\$ 151	\$ 141	\$ 102	\$ 346

**NOTE 12. INVESTMENTS AND OTHER ASSETS**

The principal components of investments and other assets in our accompanying Consolidated Balance Sheets are as follows:

	December 31,	
	2014	2013
Marketable debt securities	\$ 77	\$ 16
Equity investments in unconsolidated healthcare entities <sup>(1)</sup>	56	56
Total investments	133	72
Cash surrender value of life insurance policies	27	25
Long-term deposits	36	35
Land held for expansion, long-term receivables and other assets	188	225
<b>Investments and other assets</b>	<b>\$ 384</b>	<b>\$ 357</b>

(1) Equity earnings of unconsolidated affiliates are included in net operating revenues in the accompanying Consolidated Statements of Operations and were \$12 million and \$15 million for the years ended December 31, 2014 and 2013, respectively.

Our policy is to classify investments that may be needed for cash requirements as "available-for-sale." In doing so, the carrying values of the shares and debt instruments are adjusted at the end of each accounting period to their market values through a credit or charge to other comprehensive income (loss), net of taxes. At both December 31, 2014 and 2013, there were less than \$1 million of accumulated unrealized gains on these investments.

Table of Contents

**NOTE 13. ACCUMULATED OTHER COMPREHENSIVE LOSS**

Our accumulated other comprehensive loss is comprised of the following:

	December 31,	
	2014	2013
Adjustments for defined benefit plans	\$ (182)	\$ (24)
<b>Accumulated other comprehensive loss</b>	<b>\$ (182)</b>	<b>\$ (24)</b>

There was a tax effect allocated to the adjustments for our defined benefit plans for the years ended December 31, 2014 and 2013 of \$93 million and \$(25) million, respectively.

**NOTE 14. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE**

*Property Insurance*

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

*Professional and General Liability Insurance*

At December 31, 2014 and 2013, the aggregate current and long-term professional and general liability reserves in our accompanying Consolidated Balance Sheets were approximately \$681 million and \$711 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 1.97%, 2.45% and 1.18% at December 31, 2014, 2013 and 2012, respectively.

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

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of \$232 million, \$112 million and \$92 million for the years ended December 31, 2014, 2013 and 2012, respectively.

**NOTE 15. CLAIMS AND LAWSUITS**

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

*Governmental Reviews*

Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false

58

Table of Contents

claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. Certain of our individual facilities and Conifer have received inquiries from government agencies, and our hospitals and other healthcare-related businesses may receive such inquiries in future periods. The following material governmental reviews, which have been previously reported, are currently pending.

- *Review of Conifer's Debt Collection Activities*—As previously reported, Syndicated Office Systems, LLC, a wholly owned subsidiary of Conifer doing business under the name Central Financial Control (“CFC”), received a Civil Investigative Demand (“CID”) in August 2013 from the U.S. Consumer Financial Protection Bureau (“CFPB”) and, in July 2014, CFC received a second CID from the CFPB requesting additional information. In November 2014, the CFPB informed CFC’s external counsel that, based on its investigation, the CFPB believes CFC has not complied in limited instances with certain notification and other requirements under federal consumer financial laws with respect to credit reporting and debt collection. In January 2015, CFC commenced informal discussions with the CFPB to resolve the agency’s investigation. Based on CFC’s initial settlement proposal, management established a reserve of \$1.7 million in the three months ended December 31, 2014 to reflect its current estimate of CFC’s potential liability in connection with this matter. However, because the discussions are still in their early stages, it is not possible at this time to predict a possible range of loss with respect to the investigation. Although there can be no assurance that CFC and the CFPB will reach an agreement, the Company believes, based on current information, that the ultimate resolution of this matter will not have a material adverse effect on the consolidated results of operations, financial condition or cash flows of the Company and its subsidiaries.
- *Implantable Cardioverter Defibrillators (“ICDs”)*—We are engaged in potential settlement discussions with the U.S. Department of Justice (“DOJ”) to resolve an investigation to determine whether ICD procedures performed at 56 of our hospitals from 2002 to 2010 complied with Medicare coverage requirements. It is impossible at this time to predict with any certainty the outcome of those discussions or the amount of any potential resolution. However, based on current discussions, we believe the amount of the reserve management has established for this matter, as described below, continues to reflect our current estimate of probable liability for all of the hospitals under review as part of the government’s examination, which commenced in March 2010.
- *Clinica de la Mama Investigations and Qui Tam Action*—As previously reported, we received a subpoena in May 2012 from the Office of Inspector General (“OIG”) of U.S. Department of Health and Human Services in Atlanta seeking documents from January 2004 through May 2012 related to the relationship that certain of our Georgia and South Carolina hospitals had with Hispanic Medical Management, Inc. (“HMM”). HMM was an unaffiliated entity that owned and operated clinics that provided, among other things, prenatal care predominantly to uninsured patients. The hospitals contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. The civil investigation is being conducted by the Civil Division of the DOJ, the U.S. Attorney’s Office for the Middle District of Georgia and the Georgia Attorney General’s Office, while a parallel criminal investigation is being conducted by the Criminal Division of the DOJ and the U.S. Attorney’s Office for the Northern District of Georgia.

The investigations arose out of a qui tam action captioned *United States of America, ex. rel. Ralph D. Williams v. Health Management Associates, Inc., et al.* filed in the U.S. District Court for the Middle District of Georgia. We and four of our hospital subsidiaries are defendants in the qui tam action, which alleges that the arrangements the hospitals had with HMM violated the federal and state anti-kickback statutes and false claims acts. Both the Georgia Attorney General’s Office, on behalf of the State of Georgia, and the U.S. Attorney’s Office, on behalf of the United States, have intervened in the qui tam action. We submitted answers to the complaints filed by the relator, the State of Georgia and the United States on July 15, 2014 following the court’s denial of our motions to dismiss in June 2014. The parties have agreed to stay discovery in the case until March 31, 2015.

If we or our subsidiaries were determined to have violated the anti-kickback statutes, the government could require us to reimburse related government program payments received during the subject period, assess

Table of Contents

civil monetary penalties including treble damages, exclude individuals or subsidiaries from participation in federal healthcare programs, or seek criminal sanctions against current or former employees of our hospital subsidiary companies or the hospital companies themselves. In a Bill of Information filed on July 23, 2014 with the U.S. District Court for the Northern District of Georgia, Atlanta Division, the U.S. Attorney for that District asserted charges of one count of criminal conspiracy against a former owner of HMM (a non-employee of Tenet) related to the agreements between HMM and the Tenet hospitals described above. In a separate Bill of Information also filed with the court on July 23, 2014, the U.S. Attorney asserted charges of one count of criminal conspiracy against a former employee of a Tenet hospital, but such charges relate to an unaffiliated entity. It is impossible at this time to predict with any certainty the amount and terms of any potential resolution of these matters; however, we believe the amount of the reserve established, as described below, continues to reflect our current estimate of probable liability. We will continue to vigorously defend against the government's allegations.

Our analysis of each of these pending reviews is still ongoing, and we are unable to predict with any certainty the progress or final outcome of any discussions with government agencies at this time. Management has established reserves of approximately \$38 million in the aggregate for our potential obligations with respect to the CFPB investigation, all of the hospitals under review for their billing practices for cardiac defibrillator implantation procedures, and the Clinica de la Mama matters. Changes in the reserves may be required in the future as additional information becomes available. We cannot predict the ultimate resolution of any governmental review, and the final amounts paid in settlement or otherwise, if any, could differ materially from our currently recorded reserves.

The following previously reported governmental review was recently resolved:

- *Kyphoplasty*—From March 2009 through July 2010, seven of our hospitals became the subject of a review by the DOJ and certain other federal agencies regarding the appropriateness of inpatient treatment for Medicare patients receiving kyphoplasty, which is a surgical procedure used to treat certain spinal conditions. In January 2013, we paid \$900,000 to settle claims against one of our hospitals subject to this review, and, in April 2014, we confirmed that another hospital is no longer the subject of investigation. In January 2015, we reached final agreement with the government to settle this matter with respect to the remaining five hospitals for approximately \$2 million, which was fully reserved as of December 31, 2014.

*Ordinary Course Matters*

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

In addition, in October 2014, we received court approval of a final agreement to settle a previously disclosed class action lawsuit captioned *Doe, et al. v. Jo Ellen Smith Medical Foundation*, which was filed in the Civil District Court for the Parish of Orleans in Louisiana in March 1997. The plaintiffs pursued a claim for tortious invasion of privacy due to the fact that in April 1996 patient identifying records from a psychiatric hospital we closed in 1995 were temporarily placed in an unsecure location while the hospital was undergoing renovations. The court certified a class of over 5,000 persons; however, only eight individuals (in addition to the two plaintiffs) have been identified to date in the class certification process. The plaintiffs have asserted each member of the class is entitled to common damages under a theory of presumed "common damage" regardless of whether or not any members of the class were actually harmed or even aware of the incident. In an effort to avoid protracted litigation, the parties settled this matter in June 2014 for a maximum potential payment of \$32.5 million, subject to the number and type of claims asserted by the class members between January 15 and March 31, 2015. We made an initial deposit of \$5.5 million into an escrow account in late November 2014. The settlement will be funded in amounts and on a schedule to be agreed to by the parties. Management has established a reserve of \$11.5 million, recorded in discontinued operations, to reflect our current estimate of probable liability for this matter based on anticipated levels of class member participation.

Table of Contents

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

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the years ended December 31, 2014, 2013 and 2012:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
<b>Year Ended December 31, 2014</b>					
Continuing operations	\$ 64	\$ 25	\$ (16)	\$ —	\$ 73
Discontinued operations	6	18	(14)	—	10
	<u>\$ 70</u>	<u>\$ 43</u>	<u>\$ (30)</u>	<u>\$ —</u>	<u>\$ 83</u>
<b>Year Ended December 31, 2013</b>					
Continuing operations	\$ 5	\$ 31	\$ (10)	\$ 38	\$ 64
Discontinued operations	5	2	(1)	—	6
	<u>\$ 10</u>	<u>\$ 33</u>	<u>\$ (11)</u>	<u>\$ 38</u>	<u>\$ 70</u>
<b>Year Ended December 31, 2012</b>					
Continuing operations	\$ 49	\$ 5	\$ (49)	\$ —	\$ 5
Discontinued operations	17	—	(12)	—	5
	<u>\$ 66</u>	<u>\$ 5</u>	<u>\$ (61)</u>	<u>\$ —</u>	<u>\$ 10</u>

For the years ended December 31, 2014, 2013 and 2012, we recorded net costs of \$43 million, \$33 million and \$5 million, respectively, in connection with significant legal proceedings and governmental reviews. The amount for 2013 in the column entitled "Other" above relates to reserves assumed as part of our acquisition of Vanguard in October 2013.

**NOTE 16. INCOME TAXES**

The provision for income taxes for continuing operations for the years ended December 31, 2014, 2013 and 2012 consists of the following:

	<u>Year Ended December 31,</u>		
	<u>2014</u>	<u>2013</u>	<u>2012</u>
Current tax expense (benefit):			
Federal	\$ (12)	\$ 2	\$ (3)
State	18	4	11
	6	6	8
Deferred tax expense (benefit):			
Federal	46	(56)	117
State	(3)	(15)	—
	<u>43</u>	<u>(71)</u>	<u>117</u>
	<u>\$ 49</u>	<u>\$ (65)</u>	<u>\$ 125</u>

A reconciliation between the amount of reported income tax expense (benefit) and the amount computed by multiplying income (loss) from continuing operations before income taxes by the statutory federal income tax rate is shown below. State income tax for the year ended December 31, 2014 includes \$34 million of expense related to the

62

ATTACHMENT 6

Table of Contents

write off of expired unutilized state net operating loss carryforwards for which a full valuation allowance had been provided in prior years. A corresponding tax benefit of \$34 million is included for the year ended December 31, 2014 to reflect the reduction in the valuation allowance.

	Year Ended December 31,		
	2014	2013	2012
Tax expense at statutory federal rate of 35%	\$ 52	\$ (55)	\$ 117
State income taxes, net of federal income tax benefit	5	1	13
Expired state net operating losses, net of federal income tax benefit	34	—	—
Tax attributable to noncontrolling interests	(23)	(10)	(4)
Nondeductible acquisition costs	2	6	—
Nondeductible health insurance provider fee	3	—	—
Changes in valuation allowance	(20)	(2)	(5)
Change in tax contingency reserves, including interest	(2)	(7)	(1)
Prior-year provision to return adjustment and other changes in deferred taxes	(5)	3	3
Other items	3	(1)	2
	<u>\$ 49</u>	<u>\$ (65)</u>	<u>\$ 125</u>

Deferred income taxes reflect the tax effects of temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amount used for income tax purposes. The following table discloses those significant components of our deferred tax assets and liabilities, including any valuation allowance:

	December 31, 2014		December 31, 2013	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	\$ —	\$ 847	\$ —	\$ 681
Reserves related to discontinued operations and restructuring charges	28	—	20	—
Receivables (doubtful accounts and adjustments)	173	—	252	—
Deferred gain on debt exchanges	—	42	—	53
Accruals for retained insurance risks	329	—	335	—
Intangible assets	—	157	—	147
Other long-term liabilities	166	—	81	—
Benefit plans	451	—	294	—
Other accrued liabilities	83	—	97	—
Investments and other assets	—	4	—	27
Net operating loss carryforwards	659	—	708	—
Stock-based compensation	31	—	31	—
Other items	80	—	37	—
	<u>2,000</u>	<u>1,050</u>	<u>1,855</u>	<u>908</u>
Valuation allowance	(87)	—	(107)	—
	<u>\$1,913</u>	<u>\$ 1,050</u>	<u>\$1,748</u>	<u>\$ 908</u>

Below is a reconciliation of the deferred tax assets and liabilities and the corresponding amounts reported in the accompanying Consolidated Balance Sheets.

	December 31,	
	2014	2013
Current portion of deferred income tax asset	\$ 747	\$ 692
Deferred income tax asset, net of current portion	116	148
<b>Net deferred tax asset</b>	<u>\$ 863</u>	<u>\$ 840</u>

Table of Contents

During the year ended December 31, 2014, the valuation allowance decreased by \$20 million primarily due to the expiration of unutilized state net operating loss carryforwards. The remaining balance in the valuation allowance as of December 31, 2014 is \$87 million. During the year ended December 31, 2013, the valuation allowance increased by \$51 million, \$34 million due to the acquisition of Vanguard and \$17 million primarily due to the adjustment of deferred tax assets for state net operating loss carryforwards that have a full valuation allowance. During the year ended December 31, 2012, we reduced the valuation allowance by an additional \$5 million based on 2012 profits and projected profits for 2013.

We account for uncertain tax positions in accordance with ASC 740-10-25, which prescribes a comprehensive model for the financial statement recognition, measurement, presentation and disclosure of uncertain tax positions taken or expected to be taken in income tax returns. The table below summarizes the total changes in unrecognized tax benefits during the year ended December 31, 2014. The additions and reductions for tax positions include the impact of items for which the ultimate deductibility is highly certain, but for which there is uncertainty about the timing of such deductions. Such amounts include unrecognized tax benefits that have impacted deferred tax assets and liabilities at December 31, 2014, 2013 and 2012.

	Continuing Operations	Discontinued Operations	Total
<b>Balance at December 31, 2011</b>	<b>\$ 34</b>	<b>1</b>	<b>\$ 35</b>
Additions for prior-year tax positions	—	—	—
Reductions for tax positions of prior years	(2)	—	(2)
Additions for current-year tax positions	2	—	2
Reductions for current-year tax positions	—	—	—
Reductions due to settlements with taxing authorities	(3)	—	(3)
Reductions due to a lapse of statute of limitations	—	—	—
<b>Balance at December 31, 2012</b>	<b>31</b>	<b>1</b>	<b>32</b>
Additions for prior-year tax positions	15	—	15
Reductions for tax positions of prior years	—	—	—
Additions for current-year tax positions	3	—	3
Reductions for current-year tax positions	—	—	—
Reductions due to settlements with taxing authorities	—	—	—
Reductions due to a lapse of statute of limitations	(6)	(1)	(7)
<b>Balance at December 31, 2013</b>	<b>43</b>	<b>\$ —</b>	<b>43</b>
Additions for prior-year tax positions	—	—	—
Reductions for tax positions of prior years	(1)	—	(1)
Additions for current-year tax positions	1	—	1
Reductions for current-year tax positions	—	—	—
Reductions due to settlements with taxing authorities	—	—	—
Reductions due to a lapse of statute of limitations	(5)	—	(5)
<b>Balance at December 31, 2014</b>	<b>\$ 38</b>	<b>\$ —</b>	<b>\$ 38</b>

The total amount of unrecognized tax benefits as of December 31, 2014 was \$38 million, of which \$31 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2014 includes a benefit of \$6 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2013 was \$43 million, of which \$34 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2013 includes a benefit of \$1 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2012 was \$32 million which, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2012 includes expense of \$3 million in continuing operations attributable to an increase in our estimated liabilities for uncertain tax positions, net of related deferred tax effects.

64

Table of Contents

Our practice is to recognize interest and/or penalties related to income tax matters in income tax expense in our consolidated statements of operations. Approximately \$1 million of interest and penalties related to accrued liabilities for uncertain tax positions related to continuing operations are included in the accompanying Consolidated Statement of Operations for the year ended December 31, 2014. Total accrued interest and penalties on unrecognized tax benefits as of December 31, 2014 were \$4 million, all of which related to continuing operations.

The Internal Revenue Service ("IRS") has completed audits of our tax returns for all tax years ending on or before December 31, 2007, and of Vanguard's tax returns for fiscal years ending on or before June 30, 2004. All disputed issues with respect to these audits have been resolved and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007, and Vanguard's tax returns for fiscal years ended after June 30, 2004 remain subject to examination by the IRS.

As of December 31, 2014, approximately \$2 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

At December 31, 2014, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately \$1.6 billion pretax expiring in 2024 to 2033, (2) approximately \$28 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately \$19 million expiring in 2023 through 2034, and (4) state NOL carryforwards of \$3.3 billion expiring in 2014 through 2033 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is \$18 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs (see Note 2), the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

Table of Contents**NOTE 17. EARNINGS (LOSS) PER COMMON SHARE**

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for income (loss) from continuing operations for the years ended December 31, 2014, 2013 and 2012. Income (loss) is expressed in millions and weighted average shares are expressed in thousands.

	Net Income	Weighted Average	Per- Share
	(Loss)	Shares	Amount
	<u>(Numerator)</u>	<u>(Denominator)</u>	<u>Amount</u>
<b>Year Ended December 31, 2014</b>			
Net income attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	\$ 34	97,801	\$ 0.35
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,486	(0.01)
<b>Net income attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share</b>	<b><u>\$ 34</u></b>	<b><u>100,287</u></b>	<b><u>\$ 0.34</u></b>
<b>Year Ended December 31, 2013</b>			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	\$ (123)	101,648	\$(1.21)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
<b>Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share</b>	<b><u>\$ (123)</u></b>	<b><u>101,648</u></b>	<b><u>\$(1.21)</u></b>
<b>Year Ended December 31, 2012</b>			
Net income attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	\$ 185	104,200	\$ 1.77
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	4,726	(0.07)
<b>Net income attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share</b>	<b><u>\$ 185</u></b>	<b><u>108,926</u></b>	<b><u>\$ 1.70</u></b>

All potentially dilutive securities were excluded from the calculation of diluted earnings (loss) per share for the year ended December 31, 2013 because we did not report income from continuing operations in the period. In circumstances where we do not have income from continuing operations, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations in that period, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 2,310. Stock options (in thousands) whose exercise price exceeded the average market price of our common stock and, therefore, were not included in the computation of diluted shares for the years ended December 31, 2013 and 2012 were 755 and 2,876 shares, respectively.

**NOTE 18. FAIR VALUE MEASUREMENTS**

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of December 31, 2014 and 2013. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for

47

ATTACHMENT 6

Table of Contents

identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

<u>Investments</u>	<u>December 31, 2014</u>	<u>Quoted Prices</u>		
		<u>in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
Marketable securities — current	\$ 2	\$ 2	\$ —	\$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
Marketable debt securities — noncurrent	60	54	5	1
	<u>\$ 64</u>	<u>\$ 56</u>	<u>\$ 7</u>	<u>\$ 1</u>

<u>Investments:</u>	<u>December 31, 2013</u>	<u>Quoted Prices</u>		
		<u>in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
Marketable securities — current	\$ 1	\$ 1	\$ —	\$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
Marketable debt securities — noncurrent	62	23	38	1
	<u>\$ 65</u>	<u>\$ 24</u>	<u>\$ 40</u>	<u>\$ 1</u>

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

	<u>December 31, 2014</u>	<u>Quoted Prices</u>		
		<u>in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
Long-lived assets held and used	\$ 23	\$ —	\$ 23	\$ —

	<u>December 31, 2013</u>	<u>Quoted Prices</u>		
		<u>in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
Long-lived assets held and used	\$ 44	\$ —	\$ 44	\$ —

As described in Note 5, we recorded impairment charge in continuing operations of \$20 million and \$12 million in the years ended December 31, 2014 and 2013, respectively, for the write-down of buildings, equipment and other long-lived assets of one of our hospitals to their estimated fair values primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment.

68

ATTACHMENT 6

69

Table of Contents

The fair value of our long-term debt is based on quoted market prices (Level 1). At December 31, 2014 and 2013, the estimated fair value of our long-term debt was approximately 105.0% and 103.5%, respectively, of the carrying value of the debt.

**NOTE 19. ACQUISITIONS**

During the year ended December 31, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. We also acquired five ambulatory surgery centers, three urgent care centers, one diagnostic imaging center, SPi Healthcare, a provider of revenue cycles management, health information management and software solutions, and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was \$428 million.

During the year ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was \$1.515 billion.

We are required to allocate the purchase prices of the acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, primarily for several recent acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed. During the year ended December 31, 2014, we completed the analysis required to finalize the purchase price allocation for our acquisition of Vanguard. We have revised our Consolidated Balance Sheet as of December 31, 2013 and the related footnote disclosures to reflect the impact of these adjustments. During the years ended December 31, 2014 and 2013, we made adjustments to purchase price allocations for businesses acquired in 2013 and 2012 (other than Vanguard) that increased goodwill by approximately \$7 million and \$5 million, respectively.

Preliminary or final purchase price allocations for all the acquisitions made during the years ended December 31, 2014 and 2013 are as follows:

	<u>2014</u>	<u>2013</u>
Current assets	\$ 34	\$ 980
Property and equipment	113	2,890
Other intangible assets	46	213
Goodwill	340	2,645
Other long-term assets	2	160
Current liabilities	(30)	(1,205)
Deferred tax liabilities	(18)	(116)
Long-term liabilities	(23)	(3,725)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(21)	(268)
Noncontrolling interests	(15)	(49)
<b>Net cash paid</b>	<b><u>\$ 428</u></b>	<b><u>\$ 1,515</u></b>
<b>Gain on business combination</b>	<b><u>\$ —</u></b>	<b><u>\$ 10</u></b>

The goodwill generated from these transactions, the majority of which will not be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and increased reimbursement. Approximately \$16 million in transaction costs related to prospective and closed acquisitions were expensed during the

Table of Contents

year ended December 31, 2014, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Consolidated Statement of Operations.

Included in equity earnings of unconsolidated affiliates for the year ended December 31, 2013 is \$10 million of earnings associated with stepping up our basis in a previously held investment in an ambulatory surgery center in which we acquired a controlling interest and are now consolidating.

**Pro Forma Information - Unaudited**

The following table provides certain pro forma financial information for Tenet as if the Vanguard Health Systems acquisition had occurred at the beginning of the year ended December 31, 2012.

	<u>Year Ended December 31,</u>	
	<u>2013</u>	<u>2012</u>
Net operating revenues	<u>\$ 15,459</u>	<u>\$ 15,140</u>
Net income (loss) from continuing operations, before income taxes	<u>\$ (433)</u>	<u>\$ 294</u>

**NOTE 20. SEGMENT INFORMATION**

In the three months ended June 30, 2012, we began reporting Conifer as a separate reportable business segment. Our other segment is Hospital Operations and other. Historically, our business has consisted of one reportable segment. However, during the three months ended June 30, 2012, our Hospital Operations and other segment and our Conifer subsidiary entered into formal agreements, pursuant to which it was agreed that services provided by both parties to each other would be billed based on estimated third-party pricing terms. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Our core business is Hospital Operations and other, which is focused on operating acute care hospitals and outpatient facilities. We also own various related healthcare businesses. At December 31, 2014, our subsidiaries operated 80 hospitals with a total of 20,814 licensed beds, primarily serving urban and suburban communities in 14 states, as well as 210 outpatient centers and six health plans.

We operate revenue cycle management and patient communications and engagement services businesses under our Conifer subsidiary. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. At December 31, 2014, Conifer provided services to approximately 800 Tenet and non-Tenet hospitals and other clients nationwide.

As mentioned above, in 2012, our Conifer subsidiary and our Hospital Operations and other segment entered into formal agreements documenting terms and conditions of various services provided by Conifer to Tenet hospitals, as well as certain administrative services provided by our Hospital Operations and other segment to Conifer. The services provided by both parties under these agreements are charged to the other party based on estimated third-party pricing terms.



Table of Contents

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

	<u>December 31,</u>		
	<u>2014</u>	<u>2013</u>	<u>2012</u>
<b>Assets:</b>			
Hospital Operations and other	\$17,212	\$15,865	\$ 8,825
Conifer	929	585	219
<b>Total</b>	<b><u>\$18,141</u></b>	<b><u>\$16,450</u></b>	<b><u>\$ 9,044</u></b>
	<u>Year Ended December 31,</u>		
	<u>2014</u>	<u>2013</u>	<u>2012</u>
<b>Capital expenditures:</b>			
Hospital Operations and other	\$ 908	\$ 670	\$ 495
Conifer	25	21	13
<b>Total</b>	<b><u>\$ 933</u></b>	<b><u>\$ 691</u></b>	<b><u>\$ 508</u></b>
<b>Net operating revenues:</b>			
Hospital Operations and other	\$16,013	\$10,587	\$9,002
Conifer			
Tenet	591	404	371
Other customers	602	515	117
	<u>17,206</u>	<u>11,506</u>	<u>9,490</u>
Intercompany eliminations	(591)	(404)	(371)
<b>Total</b>	<b><u>\$16,615</u></b>	<b><u>\$11,102</u></b>	<b><u>\$ 9,119</u></b>
<b>Adjusted EBITDA:</b>			
Hospital Operations and other	\$ 1,749	\$ 1,210	\$ 1,098
Conifer	203	132	105
<b>Total</b>	<b><u>\$ 1,952</u></b>	<b><u>\$ 1,342</u></b>	<b><u>\$ 1,203</u></b>
<b>Depreciation and amortization:</b>			
Hospital Operations and other	\$ 824	\$ 526	\$ 420
Conifer	25	19	10
<b>Total</b>	<b><u>\$ 849</u></b>	<b><u>\$ 545</u></b>	<b><u>\$ 430</u></b>
<b>Adjusted EBITDA</b>	<b><u>\$ 1,952</u></b>	<b><u>\$ 1,342</u></b>	<b><u>\$ 1,203</u></b>
Depreciation and amortization	(849)	(545)	(430)
Impairment and restructuring charges, and acquisition-related costs	(153)	(103)	(19)
Litigation and investigation costs	(25)	(31)	(5)
Interest expense	(754)	(474)	(412)
Loss from early extinguishment of debt	(24)	(348)	(4)
Investment earnings	—	1	1
<b>Net income (loss) from continuing operations before income taxes</b>	<b><u>\$ 147</u></b>	<b><u>\$ (158)</u></b>	<b><u>\$ 334</u></b>

Table of Contents**NOTE 21. RECENT ACCOUNTING STANDARDS***Recently Issued Accounting Standards*

In April 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-08, "Presentation of Financial Statements (Topic 205) and Property, Plant, and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-08"). ASU 2014-08 changes the requirements for reporting discontinued operations in FASB Accounting Standards Codification Subtopic 205-20, such that a disposal of a component of an entity or a group of components of an entity is required to be reported in discontinued operations if the disposal represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. ASU 2014-08 requires an entity to present, for each comparative period, the assets and liabilities of a disposal group that includes a discontinued operation separately in the asset and liability sections, respectively, of the statement of financial position, as well as additional disclosures about discontinued operations. Additionally, ASU 2014-08 requires disclosures about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements and expands the disclosures about an entity's significant continuing involvement with a discontinued operation. This guidance will be effective for us beginning in 2015.

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2017.

**NOTE 22. SUBSEQUENT EVENTS**

In January 2015, Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. At that time and as a result of CHI's relationship with Tenet, CHI received an increase in its minority ownership position in Conifer to approximately 23.8%. CHI's ownership percentage in Conifer may experience a future one-time additional positive or negative adjustment after December 31, 2019 (to no more than 25% and no less than 20%) as a result of significant changes in Tenet's and CHI's relative relationship with Conifer at such time. CHI's ownership percentage was scheduled to increase to 9.03% on January 1, 2015 under the terms of our original agreement with CHI.

In connection with the settlement of the Valley Baptist put option, we acquired the remaining 49% non-controlling interest from the seller on February 11, 2015 in exchange for approximately \$254 million in cash, which was applied to redeemable non-controlling interest with the difference between the payment and the carrying value of approximately \$270 million recorded as additional paid-in capital. The redemption value of the put option was calculated pursuant to the terms of the operating agreement based on the operating results and the debt of the joint venture. As a result, we now own 100% of Valley Baptist as of February 11, 2015.

Table of Contents

**SUPPLEMENTAL FINANCIAL INFORMATION**

**SELECTED QUARTERLY FINANCIAL DATA  
(UNAUDITED)**

	Year Ended December 31, 2014			
	First	Second	Third	Fourth
Net operating revenues	\$ 3,926	\$ 4,042	\$ 4,179	\$ 4,468
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	\$ (32)	\$ (26)	\$ 9	\$ 61
Net income (loss)	\$ (16)	\$ (7)	\$ 18	\$ 81
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic	\$ (0.33)	\$ (0.27)	\$ 0.09	\$ 0.62
Diluted	\$ (0.33)	\$ (0.27)	\$ 0.09	\$ 0.61

	Year Ended December 31, 2013			
	First	Second	Third	Fourth
Net operating revenues	\$ 2,387	\$ 2,422	\$ 2,408	\$ 3,885
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	\$ (88)	\$ (50)	\$ 28	\$ (24)
Net income (loss)	\$ (83)	\$ (43)	\$ 36	\$ (14)
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic	\$ (0.85)	\$ (0.49)	\$ 0.28	\$ (0.24)
Diluted	\$ (0.85)	\$ (0.49)	\$ 0.27	\$ (0.24)

Quarterly operating results are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the number of covered lives managed by our health plans and the plans' ability to effectively manage medical costs; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, which impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

74

75

ATTACHMENT 6

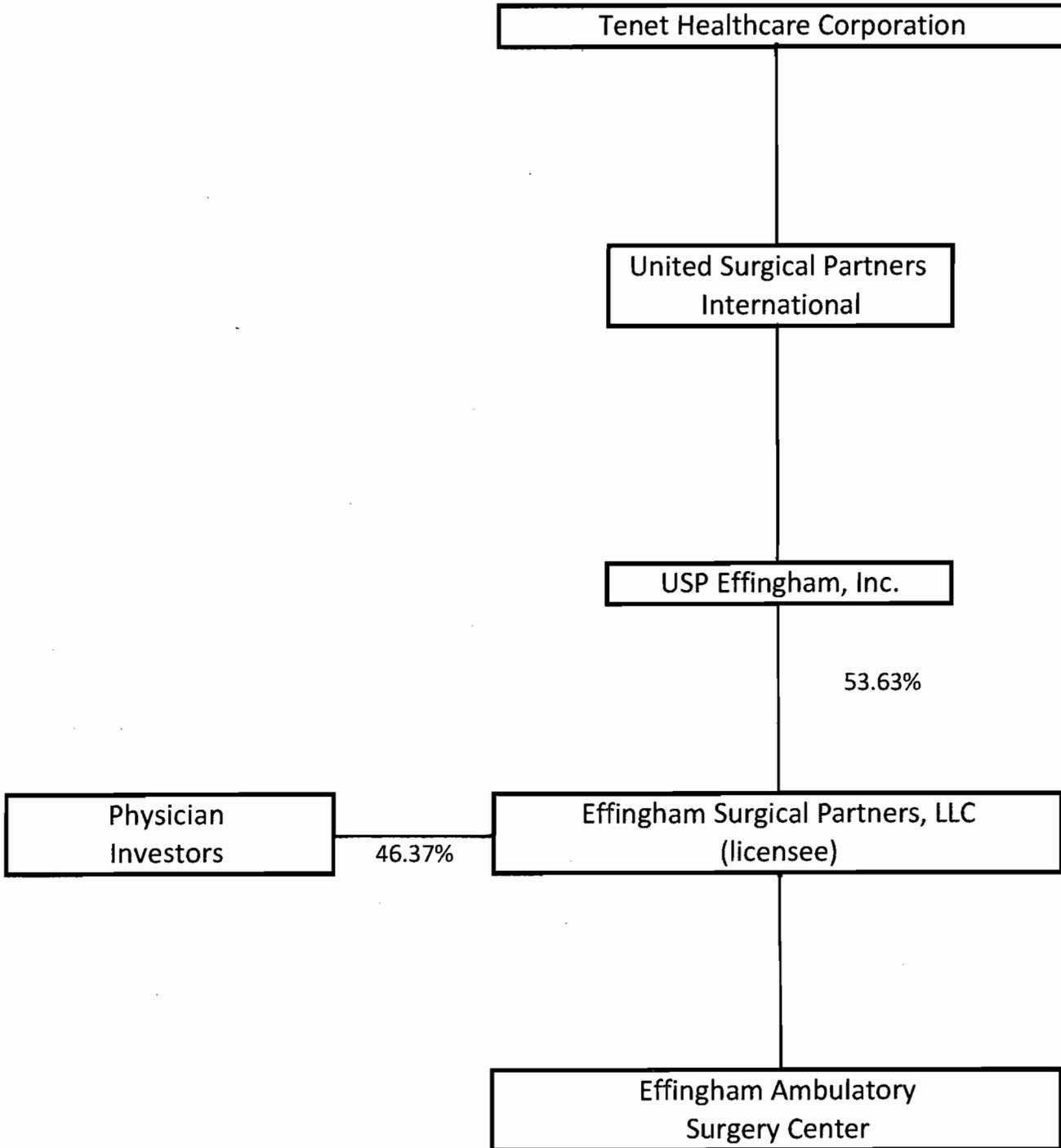
## ADDITIONAL REVIEW CRITERIA

With the filing of a signed copy of this Application, the applicants affirm the following:

- the number of operating rooms at Effingham Ambulatory Surgery Center (EASC) will not increase for a minimum of twelve months following the completion date;
- that Certificates of Good Standing issued by the Illinois Secretary of State, or equivalent documentation have been provided for each applicant;
- that Tenet Health Care Corporation intends to maintain its controlling interest in EASC for a minimum of two years following the completion date;
- failure to complete the transaction within 24 months from the date of exemption approval and failure to comply with the material change requirements of Section 130.520 will invalidate the exemption;
- it is not anticipated that the proposed change of ownership will result in any material differences to the manner in which the ASTC operates and provides benefits to the community;
- it is not anticipated that the proposed change of ownership will result in any significant cost savings or additional costs to the community or the ASTC;
- EASC will retain its current quality assurance programs and initiatives and will maintain its accreditation status;
- that the attached organizational chart identifies the control of EASC;
- that EASC's governing body will be selected in the same manner it has been selected in the past;
- a written response to the review criteria contained in Section 1110.240 has been developed, is available for review by the public on the premises and is attached; and

- no changes to the scope of services or level of care that is provided at EASC are anticipated to occur within 24 months after acquisition.

POST-APPROVAL ORGANIZATIONAL CHART



Section 1110.240  
MERGERS, CONSOLIDATIONS, and  
ACQUISITIONS/CHANGES OF OWNERSHIP

A. Impact Statement

It is not anticipated that the proposed change of ownership/change of control resulting from the proposed transaction will have any material impact on the manner in which services are provided at Effingham Ambulatory Surgery Center (EASC). No changes to the staffing levels of the ASTC, other than those changes normally associated with the ongoing operations of an ASTC, nor are any changes anticipated in the ASTC's services anticipated during the first two years following the transaction.

The change of ownership/change of control is a result of the transaction discussed in this application's NARRATIVE DESCRIPTION, through which Tenet Healthcare Corporation assumes "ultimate control" of United Surgical Partners International's (USPI) ASTCs. The operating entity will continue to be Effingham Surgical Partners, LLC.

The cost associated with the proposed change of ownership/change of control is limited to those costs identified on page two of this application; and the primary benefit of the project is the ongoing operation of the facility.

B. Access

The proposed change of ownership will not result in any change in accessibility to the ASTC's services for residents of the area. The ASTC will, following the change in control, operate with the admissions, charity care and financial assistance policies currently in place at the ASTC. Confirmation, as required by review criterion 1110.240(c) is attached.

The admissions, charity care, and financial assistance policies are attached.

Consistent with the current practices of the ASTC, services will continue to be provided to Medicaid recipients.

C. Health Care System

The proposed change of ownership will not have any impact on any other area provider.

No applicant owns or operates any health care facilities that are located within the ASTC's market area. Tenet Healthcare Corporation owns and operates four hospitals in Chicago and its western suburbs, and USPI holds minority interests in and management agreements with five ASTCs in Chicago and its western suburbs. Those hospitals and ASTCs are all located in excess of three hours from EASC, and therefore are not part of any system that would engage in the referral of patients or the sharing of services.

A photocopy of the transfer agreement between EASC and St. Anthony's Memorial Hospital in Effingham is attached. St. Anthony's Memorial Hospital is located approximately

0.4 miles from EASC. That agreement will remain in effect following the proposed transaction. Additional transfer agreements are not anticipated.

Patient transfers and referrals are made by the patient's physician and family, with no requirement that transfers or referrals be made to specific facilities. There are currently no restrictions on the use of other area care providers, and the same will apply following the proposed change of control.



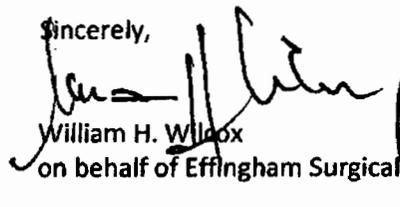
Illinois Health Facilities and  
Services Review Board  
Springfield, IL

To Whom It May Concern:

Please be advised of the following:

1. The Effingham Ambulatory Surgery Center (EASC) site, located at 904 West Temple Street in Effingham, Illinois is owned by Effingham Medical Properties.
2. No reductions in access to care will result from the proposed change of ownership/change of control of EASC, and the admissions, financial assistance and charity care policies under which EASC currently and will operate will not become more restrictive than those policies currently in place, for a minimum of two years following the completion of the change of ownership/change of control transaction.

Sincerely,

  
William H. Wilcox  
on behalf of Effingham Surgical Partners, LLC

Notarized:





904 West Temple, Effingham, Illinois 62401

## BACKGROUND OF APPLICANTS

Applicant Tenet Healthcare Corporation owns and operates four Illinois Hospitals:

- MacNeal Hospital, Berwyn
- West Suburban Medical Center, Oak Park
- Westlake Hospital, Melrose Park
- Weiss Memorial Hospital, Chicago

Applicant United Surgical Partners International holds a majority ownership position and maintains a management agreement with Effingham Ambulatory Surgery center. In addition, it holds a minority ownership interest in, and maintains a management agreement with the following ASTCs:

- Hinsdale Surgical Center, Hinsdale-7002314
- River North Same Day Surgery Center, Chicago-7002090
- 25 East Same Day Surgery, Chicago-7001969
- North Shore Surgical Center, Chicago-7003130
- Good Samaritan's Surgery Center, Mt. Vernon-7003172

DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

HF 108080

**Illinois Department of  
PUBLIC HEALTH**



**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below

**Nirav D. Shah, M.D., J.D.**

Director

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	LIC. NUMBER
04/30/2016		7003178
<b>Ambulatory Surgery Treatment Center</b>		
Effective: 05/01/2015		

**Effingham Ambulatory Surgery Center  
904 West Temple Street  
Effingham, IL 62401**

Exp. Date 04/30/2016

Lic Number 7003178

Date Printed 04/14/2015

**Effingham Ambulatory Surgery Center  
904 West Temple Street  
Effingham, IL 62401**

The face of this license has a colored background. Printed by Authority of the State of Illinois • PO #4012300 10M 3/12

FEE RECEIPT NO.



February 18, 2014

**Organization #:** 20887  
**Organization:** Effingham Surgical Partners, LLC dba Effingham Ambulatory Surgery Center  
**Address:** 904 West Temple Avenue  
**City, State, Zip:** Effingham, IL 62401-2178

**Decision Recipient:** Jean Roberts, RN  
**Survey Date:** February 5-6, 2014      **Type of Survey:** Re-Accreditation

**Accreditation Term Begins:** April 8, 2014      **Accreditation Term Expires:** April 7, 2017

**Accreditation Renewal Code:** d0ebc50820887  
**Complimentary study participation code:** 20887FREEIQI

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization.
- Statements in the "Consultative Comments" sections of the report represent the educational component of the survey. Such comments may provide helpful guidance for improvement.
- As a guide to the ongoing process of self-evaluation, periodic review of the Survey Report and the current year's *Handbook* will ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, [www.aaahc.org](http://www.aaahc.org), for information pertaining to any revisions to AAAHC policies and procedures and standards.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our *Accreditation Handbook*,

*Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit [www.aaahc.org](http://www.aaahc.org) to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.*



June 29, 2015

Illinois Health Facilities and  
Services Review Board  
525 West Jefferson  
Springfield, IL 62761

RE: Effingham Ambulatory Surgery Center Certificate of Need Application

To Whom It May Concern:

In accordance with Review Criterion 1130.520.b.3, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

Tenet Healthcare Corporation ("Tenet") has not had any adverse actions against any Illinois health care facility owned or operated by Tenet during the three (3) year period prior to the filing of this Certificate of Need application.

Tenet authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1130.520.b.3 or to obtain any documentation or information which the State Board or Agency finds pertinent to this CON application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul A. Castanon", written over a horizontal line.

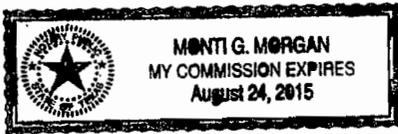
Paul A. Castanon

Handwritten initials in black ink, possibly "PC", located at the bottom center of the page.

STATE OF TEXAS            )  
  )  
COUNTY OF DALLAS        )

BEFORE ME, the undersigned notary public, duly commissioned and qualified in the state and county aforesaid, personally appeared Paul A. Castanon, Officer of Tenet Healthcare Corporation, a Delaware corporation, known to be the person who signed the foregoing instrument and acknowledged that she did execute the instrument for the purposes state herein.

SWORN TO and subscribed before me this 29 day of June 2015.



Monti G. Morgan  
Notary Public  
My Commission Expires: 8/24/15

<b>Facility Name:</b>  <b>Effingham Ambulatory Surgery Center</b>	<b>Policy And Procedure Guideline Name:</b>  Patient Screening/Pre-assessment Process  (Provision Of Care)	<b>Policy Number:</b>  Pre 100
	<b>Subject Category:</b>  Provision Of Care	<b>Effective Date:</b> 07/24/13
		<b>Revised Date:</b>
		<b>Page 1 Of 3</b>

**Policy:**

**PATIENT SAFETY IS THE FIRST PRIORITY OF THE FACILITY STAFF.** This is accomplished through a screening process that has a proven record of reliability and experience in similar facilities, through education and training of the facility staff. Further, a traditional patient evaluation (history/physical appropriate to the procedure being performed) by the physician is required to ensure proper patient selection for outpatient surgery. Patient evaluation should take place sufficiently in advance of the scheduled surgery to integrate an appropriate evaluation, necessary testing, access to consultative services, and thorough patient education to properly prepare the patient for surgery.

**Purpose:** The patient is to be pre-screened for preoperative clearance and to ensure the Effingham Ambulatory Surgery Center is the appropriate care setting for the patient.

**Attachments:** Welcome Brochure

**Procedure Guidelines:**

**PHASES**

The first phase of the process and the primary responsibility for determining the suitability of the patient for outpatient surgery rests with the referring physician and the surgeon. This surgeon understands the patients overall medical condition and risk factor for having surgery and the procedures that he is privileged for at the center. If there is doubt in the surgeon's mind as to whether a particular patient will do well as an outpatient, he should refer the patient to a general hospital and perform the necessary surgery on an in-patient basis.

The expectation for all medical staff members in screening patients is based on, in part, indications for surgery, pertinent medical history and physical, the patient's present physical status (including heart and lung physical exam), any diagnostic findings/results and assessment of the procedure's risks and benefits.

88

The **second phase** of the patient screening process is handled by means of a patient brochure(see attached copy). The brochure is given to the patient by his surgeon with an explanation of the outpatient process. The brochure is also available on the website.

The **third phase** takes place with a pre-admission screening. This phase involves the taking of a nursing assessment and medical history by a registered nurse. Our patients are encouraged to complete their medical history via Passport on our website. If the patient is unable to complete this, the nurse completes it for them during their phone or in person interview. Following the nursing assessment, an anesthesiologist performs an immediate pre induction anesthesia assessment to include the ASA risk factor, physical exam (heart/lung), and a review of medical history by nurse and review of history and physical. This final step establishes whether the patient is a suitable candidate for ambulatory surgery. If the anesthesiologist has concern regarding the patient, the matter will be discussed with the surgeon and, if appropriate, the case will be rescheduled or moved to a more appropriate setting for the patient. No charge is made to the patient for this screening.

1. Patient assessment is an ongoing process beginning with initial assessments by the surgeon, anesthesia, and nursing culminating with final patient feedback postoperatively. Interventions relating to the assessment may include, but are not limited to,
  - Verification of the patient's identity using two identifiers
  - Review of preadmission assessment
  - Appropriate baseline physician assessment
  - Review of preoperative status
  - Review of medications, including nonprescription medications, illicit drugs, and herbal medications and supplements
  - Allergies and sensitivities
  - NPO status
  - Hypothermia assessment and management
  - Pain scale assessment
  - Relevant preoperative needs of the patient and family members
  - Advance directives
  - Identification of planned procedure by the patient or his or her designee
  - Verification of surgical site, side ,or level
  - Prescribed surgical preparation
  - Prosthetic devices
  - Implantable electronic devices
  - Availability of safe transportation home and aftercare
  - Contact information for the patient's support system
  - Understanding of preoperative teaching and discharge planning
  - Documentation of information per facility policy.

<b>Facility Name:</b>  Effingham Ambulatory Surgery Center	<b>Policy And Procedure Guideline Name:</b>  Admission of Patient to Pre-Op  (Provision Of Care)	<b>Policy Number:</b>  Pre 101
	<b>Subject Category:</b>  Provision Of Care	<b>Effective Date:</b> 07/24/13
		<b>Revised Date:</b> (Insert Date)
		Page 1 Of 3

**Policy:**

The nurse is responsible for ensuring the preparation of the patient is complete. This includes physical and psychosocial needs.

**Purpose:**

To safely admit the patient to the Preoperative area.

**Procedure Guidelines:** After the patient has checked in, the receptionist should notify the Pre-operative staff by pressing the light

- CALL FOR PT. The preoperative staff should introduce themselves to the patient and family and escort the patient to the pre-op area.
- WEIGH PATIENT prior to entering pre-op (Use either the scale in consult room or the scale in pathology room to provide privacy)
- Upon entering pre-op, place a pt label on the room assignment sheet
- PT IDENTIFICATION AND SURGICAL VERIFICATION:
  1. The patient should state his/her name and date of birth and compare it to their arm band. Correct spelling of name and correct date of birth should be verified on the patient identification wrist bracelet and medical record (per policy).
  2. Verify any ALLERGIES at this time and place name band/allergy band on wrist
  3. Pt is to state surgery to be performed and their surgeon's name
  4. The procedure, site, and laterality should be verified with patient and the identified site should then be marked per site marking policy.
  5. Check the skin condition of the operative side and report any significant findings to surgeon
- SIGNING OPERATIVE CONSENT:

1. The operative consent should be checked for correctness against the doctor's order and should correlate with pt's statement and OR schedule.

2. Now the OPERATIVE CONSENT IS TO BE SIGNED

- ORAL MEDICATIONS SHOULD BE GIVEN AS SOON AS POSSIBLE ( if a pregnancy test is required, it is to be checked first.)  
When any meds are given, this needs to be documented on preop nurse note **as well as** anesthesia record.
- HAVE PT CHANGE INTO GOWN  
Pt comfort measures given, blanket, Bair Hugger, etc. Follow warming policy per CMS guidelines
- VERIFY NPO STATUS
- CHECK FOR COMPLETED H&P.
- CHECK AND SIGN OFF DOCTORS' ORDERS
- VERIFY HOME MEDICATIONS TAKEN
- PROCEED WITH OBTAINING AND DOCUMENTING Baseline VITALS, Pain assessment, IV start, Waived testing, confirming labs and further orders, etc.
- A CARDIAC RHYTHM STRIP should be obtained on all adults, signed by anesthesia, and placed in the chart.
- Once anesthesia has examined pt and explained type of anesthesia, OBTAIN ANESTHESIA PERMIT.
- Personal items

All jewelry should be removed as per policy.

If unable to remove a ring on operative hand, the ring will be removed with a ring cutter.

All personal items will become the responsibility of the adult who accompanied pt. We advise that belongings be locked in the available lockers. The family will assume responsibility of the locker key. If no one accompanied the patient, the key will be safely placed in the administrator's office until the patient is ready to get dressed postoperatively.

When applicable, prosthetic devices (glasses, dentures), are removed and placed in secured locker with other belongings by family member or caregiver.

Contact lenses will be removed per anesthesia's request

Presence of implantable electronic devices (pain pump, pacemaker, ICD) is documented.

- Family member(s) may join the patient after completion of above, if the patient desires.
- Ready for O.R. on the pre-op form, so that OR staff knows the pt may go to the OR

**During the above process, the nurse will assess the following:**

- Availability of responsible adult companion
- Educational needs / Language
- Emotional needs
- Informed
- Special needs

**Psychosocial preparation:** the teaching plan will be tailored to the patient's age, physical, mental condition, attitude to surgery, personal traits, past experiences, education, gender, cultural, and religious orientation and language preference.

Include an overview of the following:

- Preparation
- Approximate length of time in each phase
- Environmental conditions, sights, sounds, equipment
- Opportunity for questions and concerns
- Management of post-operative pain and nausea
- Deep breathing exercises
- Visiting policy
- Discharge criteria, planning
- Discharge instructions

**Medical Record**

The nurse will document all pertinent information according to facility policy.

**PERTINENT POLICIES:**

- Informed consent, Intravenous therapy, Patient education.

**Reference:** Joint Commission ASC Manual 2012 edition PC.01.02.03.  
AAAHC Accreditation Handbook 2012.  
CMS §416.52 (a)

<b>Facility Name:</b>  <b>Effingham Ambulatory Surgery Center</b>	<b>Policy And Procedure Guideline Name:</b>  <b>Guidelines for Pre-op Evaluation</b>	<b>Policy Number:</b>  <b>AC 102</b>
	<b>Subject Category:</b>  <b>Patient Care</b>	<b>Effective Date:</b> <b>7-24-13</b>
		<b>Revised Date:</b>
		<b>Page 1 Of 3</b>

## Guidelines for the Pre-op Evaluation

*(Including Local/MAC Cases)*

### Minimum Testing Guidelines for Asymptomatic, Apparently Stable Patients

- Hemoglobin concentration day of surgery:  
As requested by anesthesia
- Complete Blood Count (CBC) within 14 days of surgery:  
As requested by anesthesia
- Coagulation Profile (PT/INR & PTT)  
As requested by anesthesia
- Basic metabolic profile (SMA-7) within 14 days of surgery:  
As requested by anesthesia
- \*  $\beta$ -HCG (urine test) day of surgery:  
Any female patient capable of becoming pregnant
- \* Blood glucose concentration the day of surgery:  
All diabetic patients
- Electrocardiogram (12 lead) within three months of surgery:  
As requested by anesthesia
- Chest radiograph within one month of surgery:  
As requested by anesthesia

### **Recommend Taking the Following Medications as per Patient's Usual Routine** **(Patients can take necessary medication when NPO with a sip of water)**

Antihypertensives and Cardiac medication (No ACE Inhibitors day of surgery)  
All Psychotropics  
Asthma/COPD medications (includes inhalers, patients to bring inhalers with them to surgery center)  
Gastric Reflux / Ulcer medications (NO particulate antacids; i.e., Maalox, Tums, etc.)  
Anti-Convulsants

### ***Recommend Holding the Following Medications***

**Oral Antidiabetic Medicine** – Hold AM of surgery

**Insulin** – Hold AM of surgery

**Diuretic** – Hold AM of surgery

**Lithium** – Consult surgeon or anesthesiologist, may be continued for minor surgery

**MAO Inhibitors** – Notify surgeon and anesthesiologist

**Anticoagulants\*** - Consult surgeon or anesthesiologist

**\*Please Note** – Please consult the surgeon of the patient, patients may need to continue Aspirin or Anticoagulants in the perioperative period. Surgeons may want to consult primary care doctor or cardiologist for the management of anticoagulants in select patients.

**Herbal Medications/Supplements** – Hold all herbal medications for 2 weeks prior to surgery unless specifically approved by the patient's surgeon and/or anesthesiologist.

**Prescription diet medications** – Must be held 10 days prior to general anesthesia.

### ***Fasting Guidelines***

<b>Ingested Material</b>	<b>Minimum Fasting Period (in hours)</b>
Clear Liquids (conservative volumes of water, fruit juice without pulp – to prevent dehydration, or to take medication)	2
Breast Milk	4
Infant formula	6
Non-human milk	6
Light meal Examples: Toast, Crackers, Cereal without milk, Fruit juice with pulp	6
Normal meal Examples: Milk/Dairy, Meats, Complex Carbohydrates (Cookies, Sweet rolls, Granola Bars)	8

- A minimum of **6 hours** will be required for pre-operative fasting.
- Patients scheduled for AM surgery will be instructed NPO after midnight.
- Patient scheduled for PM surgery will be instructed NPO after 6:00 AM.
- Diabetics may have **clear liquids 2 hours** prior to surgery if the patient demonstrates apprehension with NPO instructions.
- Patient receiving LOCAL anesthesia will follow standard NPO guidelines for patients undergoing surgery.

95

**American Society of Anesthesiologist**  
***Pre-Operative Physical Status Classification System***

Class	Definition	Mortality Rate
1	A normal healthy patient	0.06-0.08%
2	A patient with mild systemic disease and no functional limitations	0.27-0.4%
3	A patient with moderate to severe systemic disease that results in functional limitations	1.8-4.3%
4	A patient with severe systemic disease that is a constant threat to life and functionally incapacitating; i.e., a patient on hemodialysis, severe COPD, severe CAD, etc.	7.8-23%
5	A moribund patient who is not expected to survive 24 hours with or without surgery	9.4-51%
6	A brain-dead patient whose organs are being harvested	100%
E	If the procedure is an emergency, the physical status classification is followed by "E" (for example, "2E")	

**Reference:**

Center for Medicare and Medicaid Services (July, 2011). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2011) Accreditation Standards and Requirements for Ambulatory Surgery Centers

The Accreditation Association for Ambulatory Care. (2011). Accreditation Handbook.

**EFFINGHAM AMBULATORY SURGERY CENTER**

**CHARITY CARE DISCOUNT POLICY**

**PURPOSE:**

The purpose of this policy is to allow the facility to provide a discount to a charity care patient in a consistent and equitable format in order to avoid the appearance of physician inducement or insurance fraud.

**PROCESS:**

- A. The three options for this care include:
  1. Match the Physician Discount – A physician’s office may, in writing, initiate the request for a charity care discount. The Administrator offers a discount amount that matches the discount given by the physician to the patients. If not, Medicare or other payors could construe it as fraudulent activity.
  2. Based on Patient’s Income – The Center will consider a patient charity care of an individual’s income for the preceding 12 months was not greater than twice the applicable poverty income guideline of the Community services Administration. At this level of poverty, the discount offered by the Administrator is 100%.
  3. Based on a Patient’s Request for Financial Assistance – The Administrator may grant a patient’s written request for financial assistance based on the individual’s current financial need. The request should be in writing from the patient and the amount of financial aid granted documented by the Administrator. The request can be accepted before or after surgery.
- B. The Administrator will document the approval of the charity discount before it is offered to the patient.
- C. The charge processor enters the charges into the Patient Accounting System and then uses the appropriate journal code to write off the amount at the agreed upon percentage. The amount written off does not qualify for recognitions as receivables or revenue in financial statements, since payment on that amount is never expected.
- D. Charity care may be determined after the day of surgery, if need is brought to the attention of the Administrator.

**EFFINGHAM AMBULATORY SURGERY CENTER**

**SELF-PAY/CASH DISCOUNT POLICY**

**PURPOSE:**

The purpose of this policy is to allow the facility to provide a discount for a self-pay or uninsured patient in a consistent and equitable format.

**PROCESS:**

- A. This discount is set by the Administrator with approval from the Governing Board.
- B. The discount of 250% of the Medicare Allowable amount plus the multiple procedure discount policy will be made available to self-pay patients and will be consistently applied.
- C. The Administrator will document the approval of the self-pay discount before it is offered to the patient.
- D. Payment in full will be expected on the day of procedure.
- E. If the patient informs the collector after the surgery has been performed that a third party payor will be utilized, the BOM may release information, in accordance with the facility's privacy policy, to the patient so that he may file with his insurance company. The following information should be provided in letter format: date of service; procedure codes and description of services performed; any diagnosis codes and the amount the patient paid for the services. We will not give the patient facility charges or the information on a claim form. The facility will not submit a claim to a third-party payor for a case performed as self-pay.
- F. The only exception to this is Workers Compensation, Medicaid, Medicare or a contracted carrier. If they present with this insurance after admission, facility will file claim to the carrier on behalf of the patient.

## PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is made and entered into as of the date of last signature below ("Effective Date") by and between Effingham Surgical Partners, L.L.C. d/b/a Effingham Ambulatory Surgery Center ("Transferring Facility") and St. Anthony's Memorial Hospital, of the Hospital Sisters of the Third Order of St. Francis ("Hospital") (individually, a "Party," collectively, the "Parties").

WHEREAS, Hospital operates an acute care hospital which provides certain medical care services;

WHEREAS, Transferring Facility operates a skilled nursing facility and needs access to the medical care provided by Hospital; and

WHEREAS, Hospital and Transferring Facility have determined that it would be in the interest of patient care to enter into a transfer agreement for the transfer of patients to Hospital.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the Parties agree as follows:

### I. PATIENT TRANSFER

- 1.1 **Request for Transfer.** Transferring Facility may request transfer of a patient to be admitted to Hospital when the patient's attending physician has determined a need for medical care and that such transfer is medically appropriate. When such determination has been made, Transferring Facility shall promptly notify Hospital of the impending transfer.
- 1.2 **Acceptance of Transfer.** Hospital agrees to accept transfers from Transferring Facility for admission in accordance with the policies and procedures of the Hospital, and subject to bed availability, staff availability, admission criteria and any other necessary criteria established by Hospital. Hospital further agrees to admit the patient as promptly as possible in accordance with Hospital's policies and procedures regarding admission and current space availability. If applicable, the Parties shall comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements with respect to such transfers.
- 1.3 **Required Paperwork.** Transferring Facility shall complete and send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the standard transfer and/or referral forms mutually agreed upon by the Parties to provide the medical and administrative information necessary to determine the appropriateness of the placement and to continue the patient's treatment. Such information may include, but is not limited to, current medical findings, diagnoses, advanced directives, rehabilitation potential, a brief summary of the course of treatment followed in the Transferring Facility, nursing and dietary information, ambulation status, and pertinent social and administrative information.

- 1.4 **Transfer Consent.** The Transferring Facility shall be solely responsible for obtaining the patient's consent to the transfer to the Hospital prior to the transfer, if the patient is competent. If the patient is not competent, the Transferring Facility shall obtain the appropriate consent from the patient's legal guardian, agent with power of attorney for health care purposes, or surrogate decisions maker of the patient.
- 1.5 **Responsibility for Transportation of Patient.** The Transferring Facility shall have responsibility for arranging transportation of the patient to the Hospital, including selection of the mode of transportation and providing or arranging for appropriate health care practitioner(s) to accompany the patient. The Hospital's responsibility for the patient's care shall begin when the patient is admitted to the Hospital and end upon patient's discharge from Hospital. The Transferring Facility shall have responsibility for arranging transportation of the patient from the Hospital back to the Transferring Facility upon patient's discharge from Hospital.
- 1.6 **Payment for Services.** The patient is primarily responsible for payment of the services provided by either the Transferring Facility or the Hospital. Each Party shall be responsible only for collecting its own payment for services rendered to the patient. This Agreement shall not be interpreted to authorize Hospital to look to the Transferring Facility to pay for services rendered to a patient transferred pursuant to this Agreement.

## II. TERM AND TERMINATION

- 2.1 **Term.** The initial term of this Agreement shall be for a period of one (1) year, commencing on the Effective Date, and terminating one (1) year thereafter. Thereafter, this Agreement shall automatically renew for four (4), additional one (1) year terms unless terminated in accordance with Section 2.2 below.
- 2.2 **Termination.** This Agreement may be terminated as follows:
- 2.2-1 **Early Termination.** This Agreement may be terminated by either Party with or without cause or penalty by delivering written notice of termination to the other Party at least thirty (30) days prior to such termination.
- 2.2-2 **Termination With Cause.** In the event either Party commits a material breach of any of the provisions of this Agreement, the non-breaching Party may terminate this Agreement upon thirty (30) days written notice; provided, however, that the breaching Party shall have the right to cure such breach within thirty (30) days after written notice of such breach and, if cured, this Agreement shall continue in full force and effect. Transferring Facility, however, is entitled to a notice of breach and opportunity to cure described in this Section 2.2-2 only once. Any Transferring Facility breach which occurs after the first notice shall be grounds for immediate termination by Hospital.

2.2-3 Termination Due to Change of Law. Notwithstanding anything herein to the contrary, if on the advice of legal counsel: (a) a Party determines that this Agreement may be interpreted to violate any present or future federal or state law ("**Law**"); (b) Hospital determines that a Law precludes it (as a result of this Agreement) from billing Medicare or another Federal Health Care Program (as defined in 42 U.S.C. § 1320a-7b(f)) for Hospital services; or (c) Hospital determines that this Agreement jeopardizes its tax-exempt status or the tax-exempt status of any of its bonds or of any affiliate; the Party making such determination may terminate this Agreement upon thirty (30) days advance written notice of the intent to terminate and the basis for the determination to the other Parties. The Parties shall use good faith efforts during such thirty (30) day period to avoid termination by amending this Agreement in such a manner so that it complies with applicable Law, does not preclude Hospital from billing a Federal Health Care Program or does not jeopardize Hospital's tax-exempt status or the tax-exempt status of its bonds, as applicable. For purposes of this Agreement, "affiliate" shall mean any successor entity of Hospital, or any entity controlled by Hospital or Hospital Sisters Health System

### III. GENERAL PROVISIONS

- 3.1 Independent Contractor Status. Except as set forth in this Agreement, no action taken by either Party, or its officers, employees or agents pursuant to this Agreement, shall be deemed to create any partnership, joint venture, association or syndicate between the Parties, nor shall any such action be deemed to confer upon either Party any express or implied right or authority to assume, or create any obligation or responsibility on behalf of, or in the name of, the other Party. The Parties to this Agreement are independent entities, contracting with each other solely for the purpose of carrying out the terms and conditions of this Agreement.
- 3.2 Insurance. Hospital and Transferring Facility agree to maintain such policies of general and professional liability insurance, or self-insurance, in amounts of at least One Million Dollars (\$1,000,000.00) per occurrence and Three Million Dollars (\$3,000,000.00) annual aggregate to insure against claims which may arise out of the performance of the terms of this Agreement. Upon request, a Party shall furnish to the other Party such certificate(s) of insurance. Each Party shall provide thirty (30) days' prior written notice to the other Party of any cancellation, nonrenewal, or of any material change in the provisions of its policies.
- 3.3 Indemnification. Each Party agrees to indemnify and hold the other harmless from any and all claims, suits, damages, fines, penalties, judgments, liabilities and expenses (including reasonable attorney's fees and court costs) arising from (a) any negligent or willful act or omission of the Party, its agents, or employees, (b) breach of this Agreement or (c) violation of a Law. Notwithstanding anything to the contrary in this Agreement, a Party's obligations with respect to indemnification for

acts described in this Section shall not apply to the extent that such application would nullify any existing insurance coverage of such Party or as to that portion of any claim of loss in which an insurer is obligated to defend or satisfy. This Section 3.3 shall survive the expiration or earlier termination of this Agreement.

- 3.4 **Ethical and Religious Directives.** The Parties acknowledge that the Hospital is operated in accordance with the Ethical and Religious Directives for Catholic Healthcare Services as promulgated, from time to time, by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church ("**Ethical and Religious Directives**"), and that the principles and beliefs of the Roman Catholic Church are a matter of conscience to Hospital. It is the intent and agreement of the Parties that neither this Agreement nor any part hereof shall be construed to require Hospital to violate said Ethical and Religious Directives in its operation and all parts of this Agreement must be interpreted in a manner that is consistent with said Ethical and Religious Directives.
- 3.5 **HIPAA.** The Parties agree that each shall comply with the Standards for Privacy of Individually Identifiable Health Information and all other regulations promulgated under Section 264 of the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and other state or federal health information privacy and security laws (collectively, "**Privacy Laws**"). Furthermore, the Parties shall promptly amend the Agreement to conform with any new or revised Privacy Laws in order to ensure that the Parties are at all times in conformance with all Privacy Laws.
- 3.6 **Compliance with Laws, Regulations, and Accreditation.** The Parties believe and intend that this Agreement complies with all relevant federal and state laws as well as relevant regulations and accreditation standards, including but not limited to Federal Health Care Program (as defined under 42 U.S.C. S 1320a-7b(f)), fraud and abuse laws (including the Anti-Kickback Statute and the Stark Law), and all of the rules and regulations promulgated pursuant to, and all of the cases or opinions interpreting such statutes and laws (collectively, "**Laws**").
- 3.7 **Exclusion from State of Federal Health Care Programs.** Each party represents and warrants to the others that it is not: excluded from participation in any Federal Health Care Program; debarred, suspended or otherwise excluded from participating in any other federal or state procurement or nonprocurement program or activity; or designated a Specially Designated National or Blocked Person by the Office of Foreign Asset Control of the U.S. Department of Treasury. The listing of Transferring Facility or any of its employees on the Office of Inspector General's exclusion list (OIG website), the General Services Administration's Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs (GSA website) for excluded individuals or entities shall constitute "exclusion" for purposes of this paragraph. The term "Federal Health Care Program" means the Medicare program, the Medicaid program, TRICARE, any health care program of the Department of Veterans Affairs, the Maternal and Child Health Services Block Grant program, any state social services block grant program, any state children's health insurance

program, or any similar program. Each Party further represents and warrants to the other Party that to its knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion. Transferring Facility shall notify Hospital in writing upon the commencement of any such exclusion or investigation, of Transferring Facility, within seven (7) business days of receiving first notice of such exclusion or investigation. Hospital shall have the right to terminate this Agreement immediately upon learning of any such exclusion and shall be kept informed of the status of any such investigation.

- 3.8 **Books and Records.** If this Agreement is a contract within the purview of Section 1861(v) (1) (I) of the Social Security Act (Section 952 of the omnibus Reconciliation Act of 1980) and the regulations promulgated at 42 C.F.R. Part 420 in implementation thereof, the Parties agree to make available to the Comptroller General of the United States ("Comptroller General"), the Secretary of the Department of Health and Human Services ("Secretary") and their duly authorized representatives, for four (4) years after the latest furnishing of services pursuant to this Agreement, access to the books, documents and records and such other information as may be required by the Comptroller General or Secretary to verify the nature and extent of the costs of services provided by each Party, respectively. If either Party, upon the approval of the other Party, carries out the duties of this Agreement through a subcontract worth Ten Thousand and 00/100 Dollars (\$10,000.00) or more over a twelve (12) month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives to the related organization's books and records.
- 3.9 **Governing Law.** This Agreement shall be construed and governed by the laws of the State of Illinois provided, however, that the conflicts of law principles of the State of Illinois shall not apply to the extent they would operate to apply the laws of another state. Unless otherwise required by law, the Parties shall submit to the jurisdiction of the courts within the County where Hospital is located in the State.
- 3.10 **Entire Agreement.** This Agreement supersedes all previous contracts or agreements between the Parties for the same Services, and constitutes the entire Agreement between the Parties. Neither Hospital nor Transferring Facility shall be entitled to benefits other than those specifically enumerated herein.
- 3.11 **Amendments.** This Agreement may be amended only by an instrument in writing signed by the Parties.
- 3.12 **Assignment.** Neither Party may assign this Agreement or the rights or obligations hereunder without the specific written consent of the other Party, except that this Agreement may be assigned by Hospital without the prior written approval of Transferring Facility to an affiliate of Hospital.

**3.13 Notice.** All notices, requests, demands and other communications under this Agreement shall be in writing and shall be deemed to have been duly given or made if sent by registered or certified mail in the United States return receipt requested, upon receipt, or when delivered in person to the addresses listed below:

**To Transferring Facility:** Effingham Surgical Partners, L.L.C.  
d/b/a Effingham Ambulatory Surgery Center  
904 W Temple  
Effingham, IL 62401  
Attn: \_\_\_\_\_

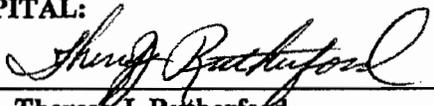
**To Hospital:** St. Anthony's Memorial Hospital  
503 N Maple St  
Effingham, IL 62401  
Attn: President & CEO

**3.14 Counterparts, Facsimile, and PDF Signatures.** The Parties agree that this Agreement may be executed in multiple originals, each of which shall be considered an original for all purposes and, collectively, shall be considered to constitute this Agreement. The Parties further agree that signatures transmitted by facsimile or in Portable Document Format (PDF) may be considered an original for all purposes, including, without limitation, the execution of this Agreement and enforcement of this Agreement.

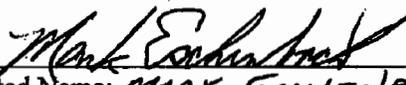
[Signature Page Follows]

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed in their respective corporate names by duly authorized officers, all on the last day and year set forth below.

**HOSPITAL:**

By:   
Theresa J. Rutherford  
President & CEO  
St. Anthony's Memorial Hospital,  
of the Hospital Sisters of the  
Third Order of St. Francis

**TRANSFERRING FACILITY:**

By:   
Printed Name: MARK ESCHENBACH  
Title: VICE PRESIDENT  
Effingham Surgical Partners, L.L.C.  
d/b/a Effingham Ambulatory  
Surgery Center

Date: July 7, 2014

Date: 6-27-14