TENET HEALTHCARE CORP
Form 10-K
February 27, 2007

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-K

x **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2006**

OR

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

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

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

13737 Noel Road
Dallas, TX 75240
(Address of principal executive offices, including zip code)

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

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

Title of each class	**Name of each exchange on which registered**
Common stock	New York Stock Exchange
6⅜% Senior Notes due 2011	New York Stock Exchange
6½% Senior Notes 2012	New York Stock Exchange
7⅜% Senior Notes due 2013	New York Stock Exchange
9⅞% Senor Notes due 2014	New York Stock Exchange
9¼% Senior Notes due 2015	New York Stock Exchange
6⅞% Senior Notes due 2031	New York Stock Exchange

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

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

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

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

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

Large accelerated filer x Accelerated filer o
Non-accelerated filer o

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

As of June 30, 2006, there were 470,653,819 shares of common stock outstanding. The aggregate market value of the shares of common stock held by non-affiliates of the Registrant as of June 30, 2006, based on the closing price of the Registrant s shares on the New York Stock Exchange that day, was approximately $2,011,321,090. For the purpose of the foregoing calculation only, all directors and the executive officers who were SEC reporting persons of the Registrant as of June 30, 2006 have been deemed affiliates. As of January 31, 2007, there were 471,605,089 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s definitive proxy statement for the 2007 annual meeting of shareholders to be held on May 10, 2007 are incorporated by reference into Part III of this Form 10-K.

CONTENTS

PART I.

ITEM 1. BUSINESS

DESCRIPTION OF BUSINESS

Tenet Healthcare Corporation operates in one line of business the provision of health care services, primarily through the operation of general hospitals. All of Tenet s operations are conducted through its subsidiaries. (Unless the context otherwise requires, Tenet and its subsidiaries are referred to herein as Tenet, the Company, we or us.) At December 31, 2006, our subsidiaries operated 64 general hospitals (including seven hospitals not yet divested at that date that are classified as discontinued operations in our Consolidated Financial Statements), a cancer hospital and two critical access hospitals, with a combined total of 16,310 licensed beds, serving urban and rural communities in 12 states. Of those general hospitals, 53 were owned by our subsidiaries and 11 were owned by third parties and leased by our subsidiaries (including one facility we owned located on land leased from a third party).

At December 31, 2006, our subsidiaries also owned or leased various related health care facilities, including two rehabilitation hospitals, a long-term acute care hospital, a skilled nursing facility and a number of medical office buildings each of which is located on the same campus as, or nearby, one of our general hospitals. In addition, our subsidiaries owned or leased physician practices, captive insurance companies and various other ancillary health care businesses, including outpatient surgery centers, diagnostic imaging centers, occupational and rural health care clinics, and interests in two health maintenance organizations, all of which comprise a minor portion of our business.

Our mission is to provide quality health care services that are responsive to the needs of the communities we serve. To accomplish our mission in the complex and competitive health care industry, our operating strategies are to (1) improve the quality of care provided at our hospitals by identifying best practices and implementing those best practices in all of our hospitals, (2) improve operating efficiencies and reduce operating costs while maintaining or improving the quality of care provided, (3) improve patient, physician and employee satisfaction, (4) improve recruitment and retention of physicians, as well as nurses and other employees, (5) increase collections of accounts receivable and improve cash flow, and (6) acquire new, or divest existing, facilities as market conditions, operational goals and other considerations warrant. We adjust these strategies as necessary in response to changes in the economic and regulatory climates in which we operate and the success or failure of our various efforts.

OPERATIONS

In the second quarter of 2006, we announced several changes to our operating structure. Previously, our four operating regions were: (1) California, which included all of our hospitals in California, as well as our hospital in Nebraska; (2) Central Northeast-Southern States, which included all of our hospitals in Georgia, Missouri, North Carolina, Pennsylvania, South Carolina and Tennessee; (3) Florida-Alabama, which included all of our hospitals in Florida, as well as our hospital in Alabama; and (4) Texas-Gulf Coast, which included all of our hospitals in Louisiana and Texas, as well a hospital in Mississippi. Our operations are now structured as follows:

- Our California region includes all of our hospitals in California and Nebraska;
- Our Central-Northeast region includes all of our hospitals in Missouri, Pennsylvania and Tennessee;
- Our Southern States region includes all of our hospitals in Alabama, Georgia, Louisiana, North Carolina and South Carolina;
- Our Texas region includes all of our hospitals in Texas; and
- Our Florida hospitals are split into two separate networks:
- Miami-Dade Health Network, which includes five hospitals in Miami-Dade and Broward counties; and
- Palm Beach Health Network, which includes six hospitals in Palm Beach and Broward counties.

All of our regions and the networks described above report directly to our chief operating officer.

We seek to operate our hospitals in a manner that positions them to compete effectively in the rapidly evolving health care environment. To that end, we sometimes decide to sell, consolidate or close certain facilities in order to eliminate duplicate services or excess capacity, or because of changing market conditions. From time to time, we make strategic acquisitions of general hospitals or enter into partnerships or affiliations with related health care businesses.

In 2006, we divested or sought to divest a total of 14 general hospitals, two of which were included in our January 2004 divestiture plan. In April 2006, we announced that we had entered into an agreement to sell Gulf Coast Medical Center in Biloxi, Mississippi, and we completed that sale in June 2006. In May 2006, we agreed to divest Alvarado Hospital Medical Center as part of a civil settlement with the U.S. Attorney in San Diego to resolve a long-running criminal case regarding physician relocation agreements at that facility. We sold Alvarado Hospital Medical Center effective January 1, 2007. In June 2006, we announced our strategic plan to divest 10 general hospitals, primarily to enhance our future profitability, provide funds to expand capital investments at our remaining hospitals and help fund our June 2006 global civil settlement with the federal government. The 10 hospitals included: (1) four in the New Orleans area because of uncertainties in the New Orleans market and the need for health care consolidation there in the aftermath of Hurricane Katrina; (2) three of our five hospitals in Philadelphia; and (3) three of our Florida hospitals. As of December 31, 2006, we had sold six of the 10 hospitals three in New Orleans and three in Florida. We continue to work towards divesting each of the six remaining hospitals slated for divestiture (which are identified with an asterisk in the table beginning on page 3), and discussions and negotiations with potential buyers are ongoing.

In addition to the proposed divestitures described above, we will no longer operate two of our Texas hospitals RHD Memorial Medical Center and Trinity Medical Center after August 2007 when our operating lease with the Metrocrest Hospital Authority expires. We are planning to open two new 100-bed acute care hospitals in the next several years one in El Paso, Texas and one in Fort Mill, South Carolina. Construction has begun on the El Paso hospital, which is targeted to open in March 2008. Our application for a certificate of need to build the Fort Mill hospital was approved in May 2006. The approval is subject to appeal by the other applicants, and we expect the appeal process to take up to two years or longer. Once construction begins, the hospital is expected to take up to an additional two years to complete. We also received approval for a 140-bed replacement hospital for East Cooper Medical Center in Mt. Pleasant, South Carolina. That replacement hospital is expected to open in early 2009.

Going forward, we will focus our financial and management resources on the 57 general hospitals and related operations that will remain after all proposed divestitures are finalized, the Metrocrest lease expires and the construction of our new hospitals in El Paso and Fort Mill is completed. Our general hospitals in continuing operations generated in excess of 97% of our net operating revenues for all periods presented in our Consolidated Financial Statements. Factors that affect our patient volumes and, thereby, our results of operations at our hospitals and related health care facilities include, but are not limited to: (1) the business environment of local communities; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local health care competitors; (8) managed care contract negotiations or terminations; (9) unfavorable publicity about us, which impacts our relationships with physicians and patients; and (10) the timing of elective procedures.

Each of our general hospitals (other than Lindy Boggs Medical Center in New Orleans, which is currently closed as a result of the effects of Hurricane Katrina) offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most offer intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. A number of the hospitals also offer tertiary care services such as open-heart surgery, neonatal intensive care and neuroscience. Five of our hospitals USC University Hospital, Saint Louis University Hospital, Hahnemann University Hospital, Sierra Medical Center and St. Christopher s Hospital for Children offer quaternary care in areas such as heart, lung, liver and kidney transplants. USC University Hospital, Sierra Medical Center and Good Samaritan Hospital also offer gamma-knife brain surgery; USC University Hospital and Saint Louis University Hospital offer cyberknife surgery for tumors and lesions in the brain, lung, neck and spine that may have been previously considered inoperable or inaccessible by radiation therapy; and Saint Louis University Hospital, Hahnemann University Hospital and USC Kenneth Norris Jr. Cancer Hospital, our facility specializing in cancer treatment on the campus of USC University Hospital, offer bone marrow transplants. In addition, our hospitals will continue their efforts to deliver and develop those outpatient services that can be provided on a quality, cost-effective basis and that we believe will meet the needs of the communities served by the facilities.

With the exception of the 25-bed Sylvan Grove Hospital located in Georgia and the 25-bed Frye Regional Medical Center Alexander Campus located in North Carolina, which are designated by the Centers for Medicare and Medicaid Services (CMS) as critical access hospitals and which have not sought to be accredited, each of our facilities that is eligible for accreditation is accredited by the Joint Commission (formerly, the Joint Commission on Accreditation of Healthcare Organizations), the Commission on Accreditation of Rehabilitation Facilities (in the case of rehabilitation hospitals), the American Osteopathic Association (in the case of one hospital) or another appropriate accreditation agency. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are, therefore, eligible to

participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. The two critical access hospitals that are not accredited also participate in the Medicare program by otherwise meeting the Medicare Conditions of Participation. Lindy Boggs Medical Center is no longer accredited due to the length of its closure as a result of damage from Hurricane Katrina.

The following table lists, by state, the general hospitals owned or leased and operated by our subsidiaries as of December 31, 2006:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	586	Owned
California			
Alvarado Hospital Medical Center/SDRI(1)	San Diego	306	Owned
Community Hospital of Los Gatos(2)	Los Gatos	143	Leased
Desert Regional Medical Center	Palm Springs	367	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	465	Owned
Encino-Tarzana Regional Medical Center*	Encino	151	Owned
Encino-Tarzana Regional Medical Center*	Tarzana	245	Leased
Fountain Valley Regional Hospital and Medical Center	Fountain Valley	400	Owned
Garden Grove Hospital and Medical Center	Garden Grove	167	Owned
Irvine Regional Hospital and Medical Center	Irvine	176	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Dimas Community Hospital	San Dimas	64	Owned
San Ramon Regional Medical Center	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	165	Owned
Twin Cities Community Hospital	Templeton	84	Owned
USC University Hospital(3)	Los Angeles	329	Leased
Florida			
Coral Gables Hospital	Coral Gables	256	Owned
Delray Medical Center	Delray Beach	403	Owned
Florida Medical Center	Fort Lauderdale	459	Owned
Good Samaritan Hospital	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Ridge Medical Center	Fort Lauderdale	332	Owned
North Shore Medical Center	Miami	357	Owned
Palm Beach Gardens Medical Center	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
Saint Mary s Medical Center	West Palm Beach	460	Owned
West Boca Medical Center	Boca Raton	185	Owned
Georgia			
Atlanta Medical Center	Atlanta	460	Owned
North Fulton Regional Hospital	Roswell	167	Leased
South Fulton Medical Center	East Point	338	Owned
Spalding Regional Hospital	Griffin	160	Owned
Sylvan Grove Hospital(4)	Jackson	25	Leased
Louisiana			

Lindy Boggs Medical Center*(5)	New Orleans	187	Owned
NorthShore Regional Medical Center(2)	Slidell	165	Leased

Hospital	Location	Licensed Beds	Status
Missouri			
Des Peres Hospital	St. Louis	167	Owned
Saint Louis University Hospital	St. Louis	356	Owned
Nebraska			
Creighton University Medical Center(6)	Omaha	334	Owned
North Carolina			
Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center	Hickory	355	Leased
Frye Regional Medical Center Alexander Campus(7)	Taylorsville	25	Leased
Pennsylvania			
Graduate Hospital*	Philadelphia	190	Owned
Hahnemann University Hospital	Philadelphia	541	Owned
Roxborough Memorial Hospital*	Philadelphia	137	Owned
St. Christopher s Hospital for Children	Philadelphia	161	Owned
Warminster Hospital*	Warminster	153	Owned
South Carolina			
East Cooper Regional Medical Center	Mt. Pleasant	100	Owned
Hilton Head Medical Center and Clinics	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital Bartlett	Bartlett	100	Owned
Texas			
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	160	Owned
Doctors Hospital	Dallas	232	Owned
Houston Northwest Medical Center	Houston	508	Owned
Lake Pointe Medical Center	Rowlett	99	Owned
Nacogdoches Medical Center	Nacogdoches	150	Owned
Park Plaza Hospital	Houston	446	Owned
Providence Memorial Hospital	El Paso	508	Owned
RHD Memorial Medical Center(8)	Dallas	155	Leased
Shelby Regional Medical Center	Center	54	Owned
Sierra Medical Center	El Paso	351	Owned
Trinity Medical Center(8)	Carrollton	207	Leased

* We continue to work toward divesting these facilities as part of the restructuring of our operations announced in January 2004 and June 2006, and discussions and negotiations with potential buyers are ongoing.

(1) Sold effective January 1, 2007.

(2) Facility and land leased from a partnership in which a Tenet subsidiary owns a 23% interest.

(3) Facility owned by us on land leased from a third party. Number of licensed beds includes USC Kenneth Norris Jr. Cancer Hospital, our 60-bed facility specializing in cancer treatment on the campus of USC University Hospital.

(4) Designated by CMS as a critical access hospital and, therefore, although not being divested, this facility is not counted among the 57 general hospitals that will remain after all proposed divestitures are finalized, the Metrocrest lease expires and the construction of new hospitals in El Paso, Texas and Fort Mill, South Carolina is completed.

(5) Closed at this time due to damage from Hurricane Katrina; the hospital s Medicare provider number has been terminated, and its Louisiana state hospital license expires on May 31, 2007.

(6) Owned by a limited liability company in which a Tenet subsidiary owns a 74% interest and is the managing member.

(7) We ceased providing services at this facility effective February 1, 2007 pending closure or sale; however, the facility remains fully licensed and is still designated by CMS as a critical access hospital.

(8) We will no longer operate these facilities after our lease with the Metrocrest Hospital Authority expires in August 2007.

As of December 31, 2006, the largest concentrations of licensed beds in our general hospitals were in California (23.6%), Florida (22.8%) and Texas (18.3%). Strong concentrations of hospital beds within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, such concentrations increase the risk that, should any adverse economic, regulatory, environmental or other development occur in these areas, our business, financial condition, results of operations or cash flows could be materially adversely affected. We currently anticipate that none of our hospitals will comprise more than 5% of our consolidated net operating revenues or 15% of our pretax income from continuing operations during 2007.

The following table shows certain information about the hospitals operated domestically by our subsidiaries for the years ended December 31, 2006, 2005 and 2004.

	Years ended December 31,		
	2006	**2005**	**2004**
Total number of facilities (at end of period)(1)	66	73	80
Total number of licensed beds (at end of period)(2)	16,310	18,259	19,668

(1) Includes all general hospitals and critical access facilities, as well as seven facilities at December 31, 2006, two facilities at December 31, 2005 and nine facilities at December 31, 2004, respectively, that are classified as discontinued operations for financial reporting purposes.

(2) Information regarding utilization of licensed beds and other operating statistics can be found in the table on page 46.

PROPERTIES

Description of Real Property. Our corporate headquarters are located in Dallas, Texas and, at December 31, 2006, our other administrative offices were located in Los Angeles and Santa Ana, California; Ft. Lauderdale, Florida; Atlanta, Georgia; St. Louis, Missouri; and Philadelphia, Pennsylvania. One of our subsidiaries leases the space for our Dallas office under an operating lease agreement that terminates on December 31, 2009, subject to our ability to exercise one or both of two five-year renewal options under the lease agreement. Other subsidiaries lease the space for our offices in Los Angeles, Santa Ana, Ft. Lauderdale, Atlanta, St. Louis and Philadelphia under operating lease agreements.

Our subsidiaries owned or leased and operated 104 medical office buildings at December 31, 2006; most of these office buildings are adjacent to our general hospitals. The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2006 are set forth in the table beginning on page 3. We believe that all of our properties, including the administrative and medical office buildings described above, are suitable for their intended purposes.

Obligations Relating to Real Property. As of December 31, 2006, we had approximately $6 million of outstanding loans secured by property and equipment, and we had approximately $23 million of capitalized lease obligations. In addition, from time to time, we lease real property to third-party developers for the construction of medical office buildings. Under our current practice, the financing necessary to construct the medical office buildings encumbers only the leasehold and not our fee interest in the real estate. In years past, however, we have at times subordinated our fee interest and allowed our property to be pledged as collateral for third-party loans. We have no contractual obligation to make payments on these third-party loans, but our property could be subject to loss in the case of default by the lessee.

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

The State of California has established standards intended to ensure that all hospitals in the state withstand earthquakes and other seismic activity without collapsing or posing the threat of significant loss of life. We are required to meet these standards by December 31, 2012, subject to a two-year extension for hospital projects that are underway in advance of that date. We currently anticipate spending approximately $516 million to comply with the requirements under these seismic regulations. In addition, over time, hospitals must meet performance standards meant to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. Ultimately, all general acute care hospitals in California must conduct all necessary seismic evaluations and be retrofitted, if needed, by 2030 to be in substantial compliance with the highest seismic performance standards. To date, we have conducted engineering studies and developed compliance plans for all of our California facilities in continuing operations. At this time, all of our general acute care hospitals in California are in compliance with all current seismic requirements.

The Americans with Disabilities Act generally requires that public accommodations, including hospitals and other health care facilities, be made accessible to disabled persons. Our facilities are subject to a negotiated consent decree involving disability access. In accordance with the terms of the consent decree, our facilities have agreed to implement disability access improvements, but have not admitted that they have engaged in any wrongful action or inaction. In the year ended December 31, 2006, we spent approximately $4 million on corrective work at our facilities, and we currently anticipate spending an additional $158 million in the next five years. Noncompliance with the requirements of the ADA or similar state laws could result in the imposition of fines against us by federal and state governments or the award of damages from us to individual plaintiffs. In addition, noncompliance with court orders and consent decrees requiring disability access improvements could result in contempt proceedings and the imposition of criminal penalties.

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

MEDICAL STAFF AND EMPLOYEES

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

Our operations depend on the efforts, abilities and experience of our employees and the physicians on the medical staffs of our hospitals, most of whom have no long-term contractual relationship with us. It is essential to our ongoing business that we attract and retain skilled employees and an appropriate number of quality physicians and other health care professionals in all specialties on our medical staffs. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain sought-after specialties and the difficulties that physicians are experiencing in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. In addition, we believe physician attrition is one of the reasons for our recent volume declines. However, we are taking a number of steps to address the problem of volume decline, one of which is centered on building stronger relationships with the physicians who admit patients both to our hospitals and to our competitors hospitals.

Although we believe we will continue to successfully attract and retain key employees, qualified physicians and other health care professionals, the loss of some or all of our key employees or the inability to attract or retain sufficient numbers of qualified physicians and other health care professionals could have a material adverse effect on our business, financial condition, results of operations or cash flows.

At December 31, 2006, the approximate number of our employees (of which approximately 27% were part-time employees) was as follows:

General hospitals and related health care facilities(1)	68,129
Administrative offices	823
Total	68,952

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

The largest concentrations of our employees (excluding those in our administrative offices) are in those states where we have the largest concentrations of licensed hospital beds:

	% of employees		% of licensed beds	
California	25.5	%	23.6	%
Florida	15.9	%	22.8	%
Texas	14.6	%	18.3	%

Union Activity and Labor Relations. At December 31, 2006, approximately 19% of our employees were represented by labor unions, and labor relations at our facilities generally have been satisfactory. We, and the hospital industry in general, are continuing to see an increase in the amount of union activity, particularly in California. As union activity increases at our hospitals, our salaries, wages and benefits expense may increase more rapidly than our net operating revenues.

On December 31, 2006, our collective bargaining agreements with the Service Employees International Union (SEIU) and the California Nurses Association (CNA) expired. These agreements relate to multiple facilities in California and two hospitals in Florida. The terms of these expired collective bargaining agreements, which cover approximately 14% of our employees, will remain in place until new agreements are reached. We are currently negotiating with these unions, as well as with the United Nurses Association of California (UNAC), regarding successor collective bargaining agreements. Although the new agreements are expected to have provisions to increase wages and benefits, the unions have agreed to an arbitration process to resolve any issues not resolved through normal renegotiations. The agreed-to arbitration process provides the greatest assurance that the unions will not engage in strike activity during the negotiation of new agreements and prevents the arbitrator from ordering us to pay market-leading wages for a particular hospital. We do not anticipate the new agreements will have a material adverse effect on our results of operations.

Nursing Shortage and Mandatory Nurse-Staffing Ratios. Factors that adversely affect our labor costs include the nationwide shortage of nurses and the enactment of state laws regarding nurse-staffing ratios. The national nursing shortage continues and remains more serious in key specialties and in certain geographic areas than others, including several areas in which we operate hospitals. The nursing shortage has become a significant operating issue to health care providers, including us, and has resulted in increased labor costs for nursing personnel. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. The vast majority of hospitals in California, including our hospitals, are not at all times meeting the state-mandated nurse-staffing ratios. We have continued to improve our monthly compliance and strive to make continued improvements in 2007.

We cannot predict the degree to which we will be affected by the future availability or cost of nursing personnel, but we expect to continue to experience significant salary, wage and benefit pressures created by the nursing shortage throughout the country and escalation in state-mandated nurse-staffing ratios in California. In response to these trends, we have enhanced salaries, wages and benefits to recruit and retain nurses. In addition, we have been and may continue to be required to increase our use of temporary personnel, which is typically more expensive than hiring full-time or part-time employees. Significant efforts are being invested in workforce development with local schools of nursing and in recruitment of new graduates and experienced nurses.

COMPETITION

Our general hospitals and other health care businesses operate in competitive environments. Competition among health care providers occurs primarily at the local level. A hospital s position within the geographic area in which it operates is affected by a number of competitive factors, including, but not limited to (1) the scope, breadth and quality of services a hospital offers to its patients and physicians, (2) the number, quality and specialties of the physicians who admit and refer patients to the hospital, (3) nurses and other health care professionals employed by the hospital or on the hospital s staff, (4) the hospital s reputation, (5) its managed care contracting relationships, (6) its location, (7) the location and number of competitive facilities and other health care alternatives, (8) the physical condition of its buildings and improvements, (9) the quality, age and state-of-the-art of its medical equipment, (10) its parking or proximity to public transportation, (11) the length of time it has been a part of the community, and (12) the charges for its services. Accordingly, each hospital develops its own strategies to address these competitive factors locally. In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions

7

from sales, property and income taxes. In certain states, including California, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

A significant factor in our future success will be the ability of our hospitals to continue to attract and retain physicians. We attract physicians by striving to equip our hospitals with technologically advanced equipment and quality physical plant, properly maintaining the equipment and physical plant, sponsoring training programs to educate physicians on advanced medical procedures, providing high-quality care to our patients and otherwise creating an environment within which physicians prefer to practice. Each hospital has a local governing board, consisting primarily of community members and physicians, that develops short-term and long-term plans for the hospital to foster a desirable medical environment for physicians. Each local governing board also reviews and approves, as appropriate, actions of the medical staff, including staff appointments, credentialing, peer review and quality assurance. While physicians may terminate their association with our hospitals at any time, we believe that by striving to maintain and improve the quality of care at our hospitals and by maintaining ethical and professional standards, we will attract and retain qualified physicians with a variety of specialties.

The health care industry as a whole is challenged by the difficulty of providing quality patient care in a competitive and highly regulated environment. We believe our *Commitment to Quality* (C2Q) initiative, which we launched in 2003, should help position us to competitively meet these challenges. We are working with physicians to implement the most current evidence-based techniques to improve the way we provide care. Our hospitals have improved substantially in quality metrics reported by the government and have been recognized by several managed care companies for their quality of care. We have seen an increase in admissions for certain service lines at our facilities that have been designated as *Centers of Excellence* by managed care companies due to their record of quality clinical outcomes. Although *Centers of Excellence* designations are limited, certain managed care companies are offering attractive financial incentives to their members to encourage the use of *Centers of Excellence* designated service lines that have consistently achieved improved clinical outcomes. We believe that quality of care improvements will continue to have the effect of increasing physician and patient satisfaction, potentially increasing our volumes as a result.

HEALTH CARE REGULATION AND LICENSING

CERTAIN BACKGROUND INFORMATION

Health care, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. Changes in the Medicare and Medicaid programs and other government health care programs, hospital cost-containment initiatives by public and private payers, proposals to limit payments and health care spending, and industry-wide competitive factors greatly impact the health care industry. The industry is also subject to extensive federal, state and local regulation relating to licensure, conduct of operations, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the health care industry are extremely complex, and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with such laws, rules and regulations, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition, results of operations or cash flows could be materially adversely affected. In addition, we are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations (discussed beginning on page 36). Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the health care industry. As part of an announced work plan that is implemented through the use of national initiatives pertaining to health care providers (including us), the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) is scrutinizing, among other things, billing practices related to coding of diagnosis-related groups, outpatient and Medicaid outlier payments, and payments to inpatient rehabilitation and psychiatric hospital units. We believe that we, and the health care industry in general, will continue to be subject to increased government scrutiny and investigations such as these, which could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Another trend impacting health care providers, including us, is the increasing number of qui tam actions brought under the federal False Claims Act. Qui tam or whistleblower actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or money from state and local agencies. Federal and state false claims laws allow private individuals to bring actions on behalf of the government, alleging that a hospital or health care provider has defrauded a

federal or state government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. Although companies in the health care industry in general, and us in particular, have been and may continue to be subject to qui tam actions, we are unable to predict the future impact of such actions on our business, financial condition, results of operations or cash flows.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

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

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

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

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

In accordance with our compliance program and our Corporate Integrity Agreement with the federal government, which are described in detail under Compliance Program below, we have in place policies and procedures concerning compliance with the Anti-kickback Statute and the Stark law, among others. In addition, our compliance and law departments systematically review all of our operations to determine the extent to which they comply with the Anti-kickback Statute, the Stark law and similar state statutes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

HHS regulations include deadlines for compliance with the various provisions of HIPAA. Effective October 1, 2005, CMS will not process electronic claims that do not meet HIPAA s electronic data transmission (transaction and code set) standards that health care providers must use when transmitting certain health care information electronically. Our electronic data transmissions are compliant with current standards.

All covered entities, including those we operate, were required to comply with the privacy requirements of HIPAA by April 14, 2003 and the security requirements of HIPAA by April 20, 2005. We are in material compliance with the privacy and security regulations, and we continue to develop training and revise procedures to address ongoing compliance. Further, all covered entities, including those we operate, must comply with the National Provider Identifier (NPI) requirements of HIPAA by May 23, 2007. An NPI is a unique 10-digit numeric identifier assigned to organizations identified as covered entities under HIPAA. We have obtained NPIs for all of our covered entities. We continue to work toward finalizing the retrieval of NPIs for our referring physicians and anticipate full compliance with the NPI requirements prior to the compliance due date.

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

HEALTH CARE FACILITY LICENSING REQUIREMENTS

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

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

Medical and surgical services and practices are extensively supervised by committees of staff doctors at each of our health care facilities, are overseen by each facility s local governing board, the members of which primarily are community

members and physicians, and are reviewed by our clinical quality personnel. The local hospital governing board also helps maintain standards for quality care, develop long-range plans, establish, review and enforce practices and procedures, and approve the credentials and disciplining of medical staff members.

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, expansion and closure of health care facilities, including findings of need for additional or expanded health care facilities or services. Certificates of need, which are issued by governmental agencies with jurisdiction over health care facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Following a number of years of decline, the number of states requiring certificates of need is once again on the rise as state legislatures are looking at the certificate of need process as a way to contain rising health care costs. As of December 31, 2006, we operated hospitals in eight states that require a form of state approval under certificate of need programs applicable to those hospitals. We are unable to predict whether we will be required or able to obtain any additional certificates of need in any jurisdiction where such certificates of need are required, or if any jurisdiction will eliminate or alter its certificate of need requirements in a manner that will increase competition and, thereby, affect our competitive position.

ENVIRONMENTAL REGULATIONS

Our health care operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations also are subject to compliance with various other environmental laws, rules and regulations. We believe it is unlikely that the cost of such compliance will have a material effect on our future capital expenditures or results of operations.

COMPLIANCE PROGRAM

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

- the compliance department has its own operating budget;

- the compliance department has the authority to hire outside counsel, to access any Tenet document and to interview any of our personnel; and

- the chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

In January 2004, our board of directors approved a compliance program charter intended to further our goal of fostering and maintaining the highest ethical standards, and valuing our compliance with all state and federal laws and regulations as a foundation of our corporate philosophy. The primary focus of the program is compliance with the requirements of the Medicare and Medicaid programs and all other government health care programs. Pursuant to the terms of the compliance program charter, the compliance department is responsible for the following activities: (1) drafting company policies and procedures related to compliance issues; (2) developing and providing compliance-related education and training to all of our employees and, as appropriate, directors, contractors, agents and staff physicians; (3) monitoring, responding to and resolving all compliance-related issues; (4) ensuring that we take appropriate corrective and disciplinary action when noncompliant or improper conduct is identified; and (5) measuring compliance with our policies and legal and regulatory requirements related to health care operations.

In order to ensure the compliance department is well-positioned to perform its duties as outlined in its charter, in 2004 we significantly expanded our compliance staff. As part of this expansion, we hired regional compliance directors and have named a compliance officer for each hospital. All hospital-based compliance officers report to regional compliance directors who report directly to our chief compliance officer.

Corporate Integrity Agreements. In June 2006, we entered into a broad civil settlement agreement with the U.S. Department of Justice and other federal agencies that concluded several previously disclosed governmental investigations, including inquiries into our receipt of certain Medicare outlier payments before 2003, physician financial

arrangements and

11

Medicare coding issues. In accordance with the terms of the settlement, we entered into a five-year corporate integrity agreement (CIA) in September 2006. The CIA establishes annual training requirements and compliance reviews by independent organizations in specific areas. In particular, the CIA requires, among other things, that we:

- maintain our existing company-wide quality initiatives in the areas of evidence-based medicine, standards of clinical excellence and quality measurements;

- maintain our existing company-wide compliance program and code of conduct;

- formalize in writing our policies and procedures in the areas of billing and reimbursement, compliance with the Anti-kickback Statute and the Stark law, and clinical quality, almost all of which were already in place when we entered into the CIA and the remainder of which have since been put into place;

- provide a variety of general and specialized compliance training to our employees, contractors and physicians we employ or who serve as medical directors and/or serve on our hospitals governing boards; and

- engage independent outside entities to provide reviews of compliance and effectiveness in five areas Medicare outlier payments, diagnosis-related group claims, unallowable costs, physician financial arrangements and clinical quality systems.

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

In March 2004, Tenet entered into a five-year corporate integrity agreement with the OIG related to North Ridge Medical Center (NRMC), one of our Florida hospitals. The OIG and Tenet voluntarily agreed to terminate this agreement in January 2007, and NRMC is now covered under the CIA we entered into in September 2006.

ETHICS PROGRAM

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

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

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

The full text of our *Standards of Conduct* is published on our website, at www.tenethealth.com, under the Ethics & Business Conduct caption in the Our Company section. A copy of our *Standards of Conduct* is also available upon written request to our corporate secretary.

PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance. We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy period April 1, 2005 through March 31, 2006, our policies provided up to $1 billion in coverage per occurrence and were subject to deductible provisions, exclusions and limits. Deductibles were 2% of insured values for windstorms, 5% for floods and earthquakes, and $1 million for fires and other perils. One sub-limit, totaling $250 million per occurrence and in the aggregate, related to flood losses as defined in the insurance policies. For California earthquakes, there was, in general, a $100 million aggregate sub-limit under the policies.

Under the policies in effect for the period April 1, 2006 through March 31, 2007, we currently have coverage totaling $600 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million each for windstorms, floods and earthquakes. The new program also has an increased deductible for wind-related claims of 5% of insured values. If our limits are exhausted during the policy period, we may be able to reinstate, in certain situations, windstorm coverage for additional premiums with certain of our carriers. With respect to fires and other perils, excluding windstorms, floods and earthquakes, the total $600 million limit of coverage per occurrence applies. Deductibles are also 5% of insured values for California earthquakes and floods, 2% of insured values for New Madrid fault earthquakes, and $1 million for fires and other perils.

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

For the policy period June 1, 2005 through May 31, 2006, our hospitals generally have a self-insurance retention per occurrence of $2 million for losses incurred during the policy period. Retentions may be lower for hospitals in states with patient compensation funds. Our captive insurance company, The Healthcare Insurance Corporation, has a self-insured retention of $13 million per occurrence. The next $10 million of claims in excess of $15 million are 97.5% reinsured by The Healthcare Insurance Corporation with independent reinsurance companies, with The Healthcare Insurance Corporation retaining the remaining 2.5% or $250,000 per claim. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies from major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $275 million. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital.

For the policy period June 1, 2006 through May 31, 2007, our hospitals generally have a self-insurance retention per occurrence of $2 million for losses incurred during the policy period. Retentions may be lower for hospitals in states with patient compensation funds. Our captive insurance company, The Healthcare Insurance Corporation, has a self-insured retention of $13 million per occurrence. The next $10 million of claims in excess of $15 million are 100% reinsured by The Healthcare Insurance Corporation with independent reinsurance companies. Claims in excess of $25 million are covered by our excess professional and general liability insurance policies from major independent insurance companies, on a claims-made basis, subject to an aggregate limit of $275 million. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital.

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

EXECUTIVE OFFICERS

The names, positions and ages of our executive officers, as of February 16, 2007, are:

	Position	Age
Trevor Fetter	President and Chief Executive Officer	47
Stephen L. Newman, M.D.	Chief Operating Officer	56
Biggs C. Porter	Chief Financial Officer	53
E. Peter Urbanowicz	General Counsel and Secretary	43
Jennifer Daley, M.D.	Chief Medical Officer and Senior Vice President, Clinical Quality	57
Timothy L. Pullen	Chief Accounting Officer and Executive Vice President	51
Reynold J. Jennings	Vice Chairman	60

Mr. Fetter was elected president effective November 7, 2002 and was named chief executive officer in September 2003. He has also been a member of the board of directors of Tenet since September 2003. From March 2000 to November 2002, Mr. Fetter was chairman and chief executive officer of Broadlane, Inc., an affiliate of Tenet. He continues to serve on Broadlane s board of directors. From October 1995 to February 2000, he served in several senior management positions at Tenet, including executive vice president and chief financial officer, then chief corporate officer and chief financial officer in the office of the president. Mr. Fetter holds an M.B.A. from the Harvard Business School and a bachelor s degree in economics from Stanford University. Mr. Fetter is a member of the board of directors of The Hartford Financial Services Group, Inc. and the Federation of American Hospitals. He is also a member of the board of trustees of the Committee for Economic Development and the Dallas Citizens Council.

Dr. Newman was appointed chief operating officer effective January 1, 2007. From March 2003 through December 2006, he served as chief executive officer of our California region. He joined Tenet in February 1999 as vice president, operations, of our former three-state Gulf States region and, in June 2000, he was promoted to senior vice president, operations, of that region. From April 1997 until he joined Tenet, Dr. Newman served in various executive positions at Columbia/HCA Inc., most recently as president of that company s three-hospital Louisville Healthcare Network. From August 1990 to March 1997, he was senior vice president and chief medical officer of Touro Infirmary in New Orleans. Prior to 1990, Dr. Newman was both associate professor of pediatrics and medicine at Wright State University School of Medicine in Dayton, Ohio, and director of gastroenterology and nutrition support at Children s Medical Center, also in Dayton. Dr. Newman holds a medical degree from the University of Tennessee, an M.B.A. from Tulane University and a bachelor s degree from Rutgers University. He completed his internship, residency and fellowship at Emory University School of Medicine. He also completed the Advanced Management Program at the University of Pennsylvania s Wharton School of Business. Dr. Newman is a member of the board of directors of the Federation of American Hospitals.

Mr. Porter joined Tenet as chief financial officer effective June 5, 2006. From May 2003 until June 2006, he served as vice president and corporate controller of Raytheon Company. In addition, Mr. Porter served as acting chief financial officer for Raytheon from April 2005 to March 2006. From December 2000 to May 2003, he was senior vice president and corporate controller of TXU Corp. and, from August 1994 to December 2000, he was chief financial officer of Northrop Grumman Corporation s integrated systems sector and its commercial aircraft division. Mr. Porter has also served as vice president, controller and assistant treasurer of Vought Aircraft Company, corporate manager of external financial reporting for LTV Corporation, and audit principal at Arthur Young & Co. He is a certified public accountant. Mr. Porter holds a master s degree in accounting from the University of Texas/Austin and a bachelor s degree in accounting from Duke University.

Mr. Urbanowicz joined Tenet as general counsel and was appointed secretary on December 22, 2003. From October 2001 to December 2003, he served as deputy general counsel of the U.S. Department of Health and Human Services. Before joining HHS, from June 2000 to October 2001, Mr. Urbanowicz was a partner in the law firm of Locke Liddell & Sapp, specializing in health care law. From January 1998 to June 2000, he was a partner in the New Orleans law firm of Liskow & Lewis and was head of that firm s health care law practice. Before joining Liskow & Lewis, Mr. Urbanowicz was a partner in the New Orleans law firm of Monroe & Lemann, where he was head of the firm s health care law practice. Mr. Urbanowicz holds a J.D. from Tulane University s School of Law and a bachelor s degree in English and political science from Tulane University. He is a member of the American Law Institute and a member of the board of directors of the Federation of American Hospitals.

Dr. Daley has served as chief medical officer and senior vice president, clinical quality since February 2003. When she first joined Tenet in July 2002, she was appointed to the newly created position of vice president, clinical effectiveness. Before joining Tenet, Dr. Daley served as director of the Center for Health Systems Design and Evaluation at Massachusetts General Hospital and Partners Health Care System from 1999 to 2002. From 1996 to 1999, Dr. Daley was vice president and medical director of health care quality at the Beth Israel Deaconess Medical Center, a Harvard teaching hospital. From 1990 to 1996, she was employed at the Department of Veterans Affairs (DVA) and served as the co-chair of the DVA s National Surgical Quality Improvement Program from 1991 to 2003. Dr. Daley has been an associate professor of medicine at the Harvard Medical School and a clinician-teacher and practicing internist at the New England Medical Center in Boston. She earned her medical degree at Tufts University School of Medicine and her bachelor s degree at Brown University.

Mr. Pullen was appointed executive vice president and chief accounting officer in August 2003. He also served as interim chief financial officer of the Company from November 2005 to June 2006. Prior to his promotion to executive vice president and chief accounting officer, Mr. Pullen served as vice president and controller of Tenet from 1995 to 1999, when he was promoted to senior vice president and controller. He joined The Hillhaven Corporation, a subsidiary of National Medical Enterprises, Inc. (which was later re-named Tenet Healthcare Corporation) (NME), in 1983 and served in various executive positions, including vice president, finance. Mr. Pullen holds an M.B.A. from Seattle University and a bachelor s degree in accounting from the Rochester Institute of Technology. He also completed the Advanced Management Program at Harvard Business School.

Mr. Jennings was appointed vice chairman effective January 1, 2007 as a transition to his anticipated retirement in mid-2007. He previously served as our chief operating officer from February 2004 through December 2006. From April 2003 to February 2004, he served as president of our former eastern division and, from June 1999 to March 2003, he served as executive vice president of our former southeast division. Mr. Jennings rejoined Tenet in 1997, first serving as regional senior vice president of our hospitals in Louisiana and Mississippi, and then as regional senior vice president of our Southern and Gulf States hospitals. From 1993 to 1996, Mr. Jennings was president and chief executive officer of Ramsay Health Care Inc. Before that, he served as senior vice president, operations, responsible for NME s acute care hospitals in Texas, Missouri and West Florida from 1991 to 1993. His career experience includes executive directorships at a number of acute care hospitals. Mr. Jennings holds an M.B.A. from the University of South Carolina and a bachelor s degree in pharmacy from the University of Georgia. Mr. Jennings is also a fellow of the American College of Healthcare Executives.

COMPANY INFORMATION

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

Our website, www.tenethealth.com, also offers, free of charge, extensive information about our operations and financial performance, including a comprehensive series of investor pages. These pages include real-time access to our annual, quarterly and current reports (and amendments to such reports) and other filings made with, or furnished to, the SEC. The information found on our website is not part of this or any other report we file with or furnish to the SEC.

FORWARD-LOOKING STATEMENTS

The information in this report includes forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. These forward-looking statements represent management s current belief, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors many of which we are unable to predict or control that may cause our actual results, performance or achievements, or health care industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the risks described in Item 1A of this report and the following:

- Our ability to satisfactorily and timely collect our patient accounts receivable;
- Our ability to identify and execute on measures designed to reduce or control costs;

- The availability and terms of debt and equity financing sources to fund the needs of our business;
- Changes in our business strategies or development plans;
- The impact of natural disasters, including our ability to reopen facilities affected by such disasters;
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, health care;
- Various factors that may increase the cost of supplies;
- National, regional and local economic and business conditions;
- Demographic changes; and
- Other factors and risk factors referenced in this report and our other public filings.

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

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

ITEM 1A. RISK FACTORS

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

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

We currently have thousands of managed care contracts with various health maintenance organizations and preferred provider organizations. The amount of our managed care net patient revenue from our continuing general hospitals during the year ended December 31, 2006 was $4.4 billion, which represented approximately 52.3% of our total net patient revenues. Approximately 59% of our managed care net patient revenues through December 31, 2006 were derived from our top ten managed care payers. At December 31, 2006, approximately 54% of our net accounts receivable related to continuing operations were due from managed care payers.

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

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

For the year ended December 31, 2006, approximately 26.5% of our net patient revenues from our continuing general hospitals were received from the Medicare program, and approximately 9% of our net patient revenues from our continuing general hospitals were received from various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization

review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are

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

Our business continues to be adversely affected by a high volume of uninsured and underinsured patients.

Like other organizations in the health care industry, we continue to provide services to a high volume of uninsured patients and more patients than in prior years with an increased burden of co-payments and deductibles as a result of changes in their health care plans. Although the discounting components of our *Compact with Uninsured Patients* have reduced our provision for doubtful accounts recorded in our Consolidated Financial Statements, they are not expected to mitigate the net economic effects of treating uninsured or underinsured patients. We continue to experience a high level of uncollectible accounts, and, unless our business mix shifts toward a greater number of insured patients or the trend of higher co-payments and deductibles reverses, we anticipate this high level of uncollectible accounts to continue.

We operate in a highly competitive industry, and competition is one reason for our recent declines in patient volumes.

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

The ultimate resolution of claims, lawsuits and investigations could adversely affect our financial condition.

In June 2006, Tenet entered into a broad civil settlement agreement with the U.S. Department of Justice and other federal agencies that concluded several previously disclosed governmental investigations, including inquiries into our receipt of certain Medicare outlier payments before 2003, physician financial arrangements and Medicare coding issues, as well as various whistleblower actions brought by private citizens on behalf of the government concerning allegedly excessive or inappropriate claims to government health care programs. With this global settlement and the settlement of a number of other matters, which were disclosed in prior filings, we resolved the majority of the lawsuits and investigations related to legacy issues that had been ongoing for the past several years. For the year ended December 31, 2006, we recorded total costs of $731 million in connection with significant legal proceedings and investigations.

While we cannot predict the likelihood of future claims or inquiries, new matters may be initiated against us from time to time. These matters could:

- 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;
- Cause us to incur substantial expenses;
- Require significant time and attention from our management; and
- Cause us to close or sell hospitals or otherwise modify the way we conduct business.

The results of claims, lawsuits and investigations also cannot be predicted. We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. If non-litigated resolution is not appropriate or possible with respect to a particular matter, we will defend ourselves vigorously. The ultimate resolution of significant claims against us, individually or in the aggregate, whether as a result of litigation or settlement, could have a material adverse effect on our business (both in the near and long term), financial condition, results of operations or cash flows.

17

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

Our operations depend on the efforts, abilities and experience of our employees and the physicians on the medical staffs of our hospitals, most of whom have no long-term contractual relationship with us. It is essential to our ongoing business that we attract and retain skilled employees and an appropriate number of quality physicians and other health care professionals in all specialties on our medical staffs. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain sought-after specialties and the difficulties that physicians are experiencing in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. In addition, we believe physician attrition is one of the reasons for our recent volume declines. If we are unable to build stronger relationships with the physicians who admit patients both to our hospitals and to our competitors hospitals, we expect these volume declines to continue. In general, the loss of some or all of our key employees or the inability to attract or retain sufficient numbers of qualified physicians and other health care professionals could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Factors that adversely affect our labor costs include union activity, the nationwide shortage of nurses and the enactment of state laws regarding nurse-staffing ratios. At December 31, 2006, approximately 19% of our employees were represented by labor unions, and we (and the hospital industry in general) are seeing an increase in the amount of union activity, particularly in California. Further, the national nursing shortage continues and remains more serious in key specialties and in certain geographic areas than others, including several areas in which we operate hospitals. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. In response to these trends, we have enhanced salaries, wages and benefits to recruit and retain nurses. We cannot predict the degree to which we will be affected by future union activity or the future availability or cost of nursing personnel, but we expect to continue to experience significant salary, wage and benefit pressures. In addition, we have been and may continue to be required to increase our use of temporary personnel, which is typically more expensive than hiring full-time or part-time employees.

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

As of December 31, 2006, the largest concentrations of licensed beds in our general hospitals were in California (23.6%), Florida (22.8%) and Texas (18.3%). Such concentrations increase the risk that, should any adverse economic, regulatory, environmental or other development occur in these areas, our business, financial condition, results of operations or cash flows could be materially adversely affected.

Specifically, a natural disaster or other catastrophic event could affect us more significantly than other companies with less geographic concentration. In the recent past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida and Texas, as well as in Louisiana, and the patient populations in those states. Our California operations could be adversely affected by a major earthquake in that state. Moreover, we currently anticipate spending approximately $516 million through 2013 to comply with the requirements under California s seismic regulations for hospitals.

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

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

The cost and future availability of insurance, as well as insurance policy limits, may have an adverse effect on our operations.

We continue to experience unfavorable pricing and availability trends in the professional and general liability insurance markets and increases in the size of claim settlements and awards in this area. If these trends continue, they could have an adverse effect on our business and financial results. All reinsurance and any excess professional and general liability insurance we purchase are subject to policy aggregate limitations. Any limits paid, in whole or in part, could deplete or reduce the excess limits available to pay any other material claims applicable to the relevant policy period. If such policy aggregate limitations should be partially or fully exhausted in the future, or actual payments of claims materially exceed projected estimates of claims, our financial condition, results of operations or cash flows could be materially adversely affected.

Our operations have not been profitable for the last several years, and, if our turnaround strategy is not successful, our business operations and financial results may not improve and could worsen.

We reported losses from continuing operations for the years ended December 31, 2003, 2004, 2005 and 2006. These results of operations reflect the challenges we have faced in restructuring our business to focus on a smaller group of general hospitals. We have been executing a turnaround strategy designed to improve profitability and margins through initiatives to grow volumes, maintain adequate reimbursement levels and control costs. However, our turnaround timeframe has been impacted by industry trends such as bad debt levels and a company-specific volume challenge, which continue to negatively affect our revenue growth. If our turnaround strategy is not successful or the industry trends worsen, we may not be able to achieve or sustain future profitability.

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

As a result of the various factors that affect our industry generally and our business specifically, we may from time to time be required to record charges in our results of operations. For example, as a result of our recent financial trends and the current outlook for our future operating performance, we recorded goodwill and long-lived asset impairment charges of approximately $357 million in the year ended December 31, 2006, approximately $160 million in the year ended December 31, 2005 and approximately $1.1 billion during the fourth quarter of 2004. Based on future financial trends and the possible impact of negative trends on our future outlook, further impairments of long-lived assets and goodwill may occur, and we will incur additional restructuring charges. Future restructuring of our operating structure that changes our goodwill reporting units could also result in further impairments of our goodwill. Any such charges could adversely affect our results of operations.

Our substantial leverage could have a significant effect on our operations.

We are a highly leveraged company. As of December 31, 2006, we had approximately $4.8 billion of total long-term debt, as well as approximately $190 million in letters of credit outstanding under our senior secured revolving credit facility, which is collateralized by patient accounts receivable at our acute care and specialty hospitals. In addition, from time to time, we expect to engage in various capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time.

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

- Our credit agreement and the indentures governing our senior notes contain, and any future debt obligations may contain, covenants that, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. If we do not comply with these obligations, it may cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately.

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

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

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

19

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

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

ITEM 3. LEGAL PROCEEDINGS

On June 28, 2006, Tenet entered into a broad civil settlement agreement with the U.S. Department of Justice (DOJ) and other federal agencies that concluded several previously disclosed governmental investigations, including inquiries into our receipt of certain Medicare outlier payments before 2003, physician financial arrangements and Medicare coding issues, as well as various whistleblower actions brought by private citizens on behalf of the government concerning allegedly excessive or inappropriate claims to government health care programs. With this global settlement and the settlement of a number of other matters, which were disclosed in prior filings, we resolved the majority of the lawsuits and investigations related to legacy issues that had been ongoing for the past several years.

Currently pending material legal proceedings and investigations that are not in the ordinary course of business are set forth below. Where specific amounts are sought in any pending legal proceeding, those amounts are disclosed. For all other matters, where the possible loss or range of loss is reasonably estimable, an estimate is provided. Where no estimate is provided, the possible amount of loss is not reasonably estimable at this time or the loss is not probable. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. The results of claims, lawsuits and investigations also cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial condition, results of operations or cash flows. We undertake no obligation to update the following disclosures for any new developments.

SHAREHOLDER DERIVATIVE ACTIONS AND SECURITIES MATTER

***In re Tenet Healthcare Corporation Derivative Litigation*, Lead Case No. 01098905 (Superior Court of California, County of Santa Barbara)**

On January 12, 2006, we announced that we had reached an agreement in principle to settle the shareholder derivative action filed in the Superior Court of California, County of Santa Barbara, against certain current and former members of our board of directors and former members of senior management by shareholders purporting to pursue their actions on behalf of Tenet and for our benefit. Plaintiffs alleged, among other things, that the individual defendants breached their fiduciary duties and engaged in gross mismanagement by allegedly ignoring indicators of the lack of control over our accounting and management practices, allowing the Company to engage in improper conduct, permitting misleading information to be disseminated to shareholders, failing to monitor hospitals and doctors to prevent improper action, and otherwise failing to carry out their duties and obligations to the Company. The lead plaintiff further alleged that the defendants violated the California insider trading statute. In March 2006, we paid a $5 million award of attorneys fees in connection with the settlement. On May 4, 2006, we received final court approval of the settlement, which covers all the individuals named in the litigation.

On July 6, 2006, two objectors to the settlement and their counsel filed a notice of appeal with the Santa Barbara Superior Court purporting to appeal several orders that the court entered in connection with its approval of the settlement, including the order overruling their original objections to the settlement. We believe that the trial court s orders were correct and are defending those orders on appeal.

***In re Tenet Healthcare Corporation Derivative Litigation*, Case No. CV-03-0011-RSWL (U.S. District Court for the Central District of California)**

A consolidated shareholder derivative action is pending in federal district court in California against certain current and former members of our board of directors and former members of senior management. Plaintiffs purport to pursue the matter on behalf of Tenet and for our benefit. We are also named as a nominal defendant. We anticipate that this federal derivative

litigation will be dismissed now that the state court in Santa Barbara has approved the settlement of the state derivative litigation, subject to the appeal described above. The federal court has stayed all proceedings in this case until our motion to dismiss is filed and resolved. Counsel for plaintiffs, however, have filed a motion seeking $10 million in fees, claiming that they brought about the settlement in the state derivative litigation. We have opposed the motion, which is fully briefed. The parties are awaiting the court s ruling, but no ruling date has been scheduled.

Plaintiffs Third Consolidated Amended Shareholder Derivative Complaint sets forth the following claims against the following defendants: (1) alleged breach of fiduciary duty against defendants Jeffrey Barbakow, Bernice Bratter, Sanford Cloud, Jr., Maurice DeWald, Michael Focht, Van B. Honeycutt, Robert Kerrey, Lester Korn, Thomas Mackey, Raymond Mathiasen and Christi Sulzbach; (2) alleged insider trading and misappropriation in violation of the common law against defendants Barbakow, Mackey, Mathiasen and Sulzbach; (3) alleged unjust enrichment against defendants Barbakow, Mackey, Mathiasen and Sulzbach; (4) alleged violations of Section 10(b) of and Rule 10b-5 under the Securities Exchange Act of 1934 (the Exchange Act) against defendant Barbakow; and (5) alleged violations of Section 14(a) of and Rule 14a-9 under the Exchange Act against defendants Barbakow, Bratter, Cloud, DeWald, Focht, Honeycutt, Kerrey and Korn.

***Rudman Partners, L.P., et al. v. Tenet Healthcare Corporation, et al.*, Case No. CV06-3455 RJK (CWx) (U.S. District Court for the Central District of California, filed June 6, 2006)**

On June 6, 2006, four purported Tenet shareholders who opted out of the settlement of the federal securities class action lawsuit entitled *In Re Tenet Healthcare Corporation Securities Litigation* filed a civil complaint in the U.S. District Court for the Central District of California against the Company, certain former executive officers of the Company and KPMG LLP (KPMG), the Company s independent registered public accounting firm. Plaintiffs assert substantively the same factual allegations concerning Tenet s receipt and disclosure of Medicare outlier payments that were asserted in the federal securities class action lawsuit. Specifically, plaintiffs allege the following claims: (1) that the Company, KPMG and former executives Jeffrey Barbakow, David Dennis and Thomas Mackey are liable for securities fraud under Section 10(b) of and Rule 10b-5 under the Exchange Act; and (2) that defendants Jeffrey Barbakow, David Dennis, Thomas Mackey, Raymond Mathiasen, Barry Schochet and Christi Sulzbach are liable for control person liability pursuant to Section 20(a) of the Exchange Act. Plaintiffs seek an undisclosed amount of compensatory damages and reasonable attorneys fees and expenses. Tenet and each of the individual defendants filed answers to plaintiffs complaint on September 15, 2006.

SEC INVESTIGATION

The Securities and Exchange Commission initiated a formal investigation of Tenet and certain of our current and former directors and officers, whom the SEC did not specifically identify, by order dated April 22, 2003. The confidential investigation concerns whether our disclosures in our financial reports relating to Medicare outlier reimbursements and stop-loss payments under managed care contracts were misleading or otherwise inadequate, and whether there was any improper trading in our securities by certain of our current and former directors and officers. The SEC served a series of document requests and subpoenas for testimony on Tenet and certain of our current and former employees, officers and directors, as well as KPMG. The securities law provisions implicated in the investigation include Section 17(a) of the Securities Act, Section 10(b) of the Exchange Act, regulations associated with those statutes, and Rules 12b-20, 13a-1 and 13a-13 under the Exchange Act.

On April 27, 2005, we announced that we had received a Wells Notice from the staff of the SEC in connection with the investigation, and that we had been informed that Wells Notices had also been issued to certain former senior executives of the Company who left their positions in 2002 and 2003, including the former chief executive officer, former chief operating officer, former general counsel, former chief financial officer, former chief accounting officer and former senior vice president of government programs. A Wells Notice indicates that the SEC s staff intends to recommend that the agency bring a civil enforcement action against the recipients for possible violations of federal securities laws. Recipients of Wells Notices have the opportunity to respond before the SEC s staff makes its formal recommendation on whether any action should be brought. We submitted a response on May 13, 2005.

In mid-2005, the SEC also began investigating allegations made by a former employee that inappropriate contractual allowances for managed care contracts may have been established at three of our California hospitals through at least fiscal year 2001. At the request of the audit committee of our board of directors, the board s independent outside counsel, Debevoise & Plimpton LLP (Debevoise), conducted an investigation of these allegations utilizing the forensic accounting services of Huron Consulting Group (Huron). This investigation was expanded and included determining whether similar issues might have affected other Tenet hospitals during the periods mentioned in the allegations and any other pertinent periods. During the first quarter of 2006, Debevoise and Huron completed their investigation and presented the results of their findings to the audit committee. Based on these findings, the audit committee determined that it was necessary to restate

our previously reported financial statements. The restated financial statements were presented in our Annual Report on Form 10-K for the year ended December 31, 2005, and the restatement adjustments were described in Note 2 to the Consolidated Financial Statements therein. During the pendency of the investigation, we provided regular updates to the SEC, and we subsequently advised the SEC of the ultimate findings. Throughout, we have cooperated with the SEC with respect to its investigation, including responding to subsequent requests for voluntary production of documents, as well as a subpoena request for documents dated October 6, 2005.

WAGE AND HOUR ACTIONS

On September 28, 2004, the court granted our petition to coordinate two pending wage and hour actions, *McDonough, et al. v. Tenet Healthcare Corporation* and *Tien, et al. v. Tenet Healthcare Corporation*, in Los Angeles Superior Court. The *McDonough* case was originally filed on June 24, 2003 in San Diego Superior Court and the *Tien* case was originally filed on May 21, 2004 in Los Angeles Superior Court. The coordinated proposed class action lawsuit alleges that our hospitals violated certain provisions of the California Labor Code and applicable California Industrial Welfare Commission Wage Orders with respect to meal breaks, rest periods and the payment of one hour s compensation for meal breaks or rest periods not taken. The complaint in the *Tien* case also alleges that we have improperly rounded off time entries on timekeeping records and that our pay stubs do not include all information required by California law. Plaintiffs are seeking back pay, statutory penalties and attorneys fees, and seek to certify this action on behalf of virtually all nonexempt employees of our California subsidiaries. We contend that certification of a class in the action is not appropriate because our uniform policies comply and have complied with the applicable Labor Code and Wage Orders. Our policies are intended to ensure that: (1) employees who miss a rest period or meal break on any given day are appropriately paid; and (2) our rounding off practices and pay stubs comply with California law. In addition, we contend that each of these claims must be addressed individually based on its particular facts and, therefore, should not be subject to class certification.

Two other proposed class actions, *Pagaduan v. Fountain Valley Regional Medical Center*, filed in Orange County Superior Court, and *Falck v. Tenet Healthcare Corporation*, pending in U.S. District Court for the Central District of California, involve allegations regarding unpaid overtime. These lawsuits allege that our pay practices since 2000 for California-based 12-hour shift employees violate California and, in the *Falck* case, federal overtime laws by virtue of the alleged failure to include certain payments known as Flexible (or California) Differential payments in the regular rate of pay that is used to calculate overtime pay. These payments are made to 12-hour shift employees when they do not work a shift that is exactly 12 hours. We contend that these differential payments need only be included in the regular rate of pay when they actually are paid (as opposed to merely being potentially payable), and that they always are included in the regular rate calculation in these circumstances. Plaintiffs in both cases are seeking back pay, statutory penalties and attorneys fees.

On February 1, 2007, the Los Angeles Superior Court ruled that the *Pagaduan* case be coordinated with the previously coordinated *McDonough* and *Tien* cases already pending there, as described above. We will now be defending these proposed class action wage and hour cases in a single court.

INVESTIGATION BY LOUISIANA ATTORNEY GENERAL S OFFICE

In connection with an investigation into patient deaths that occurred at various hospitals and nursing homes following Hurricane Katrina, the Louisiana Attorney General s Office conducted a review of events that occurred during the hurricane at two Tenet hospitals in New Orleans Memorial Medical Center (which we have since divested) and Lindy Boggs Medical Center (which is currently closed). On October 1, 2005, representatives of the Louisiana Attorney General s Office conducted a search of Memorial s campus pursuant to a search warrant issued by an Orleans Parish state judge on September 30, 2005. Certain records and other materials were removed, including materials from a long-term acute care facility on Memorial s campus, which was managed and operated under separate license by LifeCare Holdings Inc., which is not affiliated with us. The Attorney General s Office also issued subpoenas to the Company and Memorial requesting documents pertaining to the matters under investigation and events occurring at the hospital during and after the hurricane. In addition, the Attorney General subpoenaed certain individuals he wanted to question on these matters, including a number of our employees.

We learned in mid-July 2006 that the Louisiana Attorney General had referred the findings of his ten-month investigation to the New Orleans District Attorney. The Attorney General s Office also announced in July 2006 that it had issued arrest warrants for two nurses who were employees of Memorial and one doctor who was not our employee, but was on the medical staff at Memorial, alleging that they may have administered pain medication that hastened the deaths of four patients of LifeCare s facility in the aftermath of the hurricane. These individuals have not yet been charged.

TAX MATTERS

Internal Revenue Service Disputes

2003 Revenue Agent s Report. In May 2003, the Internal Revenue Service (IRS) completed an examination of our federal income tax returns for fiscal years ended May 31, 1995, 1996 and 1997 and issued a Revenue Agent s Report. During 2005, we resolved several disputed issues with the IRS and paid approximately $8 million, which was comprised of $23 million of tax plus accrued interest of $15 million less prior payments of $30 million. Among the resolved issues was a disputed adjustment with respect to the timing of the recognition of income for tax purposes pertaining to Medicare and Medicaid net revenues, which we resolved by agreeing to spread the impact of the disputed adjustment over fiscal years ended May 31, 1995 through May 31, 2002.

After the settlement, the IRS issued a statutory notice of tax deficiency for $67 million in the fourth quarter of 2005 related to the remaining disputed items for fiscal years May 31, 1995, 1996 and 1997. The principal issues in dispute included the deductibility of a portion of the civil settlement we paid to the federal government in 1994 related to our discontinued psychiatric hospital business and the computation of depreciation expense with respect to certain capital expenditures incurred during the fiscal years at issue. In early 2006, we filed a petition to contest the tax deficiency notice through formal litigation in Tax Court. Subsequently, on November 22, 2006, we announced that we had reached a settlement with the IRS to resolve the principal disputed issues, and, in December 2006, we paid $80 million as an advance payment of taxes and interest owed under the settlement with respect to those matters. One issue, relating to the timing of the deductibility of certain contributions to our health and welfare benefit plans, remains to be resolved with the IRS in connection with the tax examination for fiscal years ended May 31, 1995, 1996 and 1997. We are working with the IRS to resolve this matter without litigation; we anticipate that the ultimate resolution of this remaining issue and final settlement of this case will involve a cash payment to the IRS of no more than $5 million.

2006 Revenue Agent s Report. In September 2006, the IRS completed its examination of our federal tax returns for fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002. In October 2006, the IRS issued a Revenue Agent s Report (RAR) in which it proposed to assess an aggregate tax deficiency of $207 million plus interest. The RAR addresses several disputed issues, including the computation of depreciation expense on certain capital expenditures, the deductibility of a portion of certain civil settlements we paid to the federal government, and the deductibility of a loss incurred on the disposition of a business. In the aggregate, the disputed issues comprise approximately $82 million, plus interest thereon of $28 million as of December 31, 2006. We believe our original deductions were appropriate, and we have appealed each of these disputed issues by filing a protest with the Appeals Division of the IRS. We believe we have adequately reserved for all probable tax matters presented in the RAR, including interest. We presently cannot determine the ultimate resolution of the disputed issues.

Of the aggregate proposed tax deficiency of $207 million, approximately $125 million is attributable to issues that are not in dispute. After taking into account net operating losses from 2004, which offset a portion of the undisputed tax deficiency, the remaining undisputed amount is reduced to approximately $85 million. We paid this undisputed tax deficiency of $85 million, plus interest thereon of $25 million, in December 2006.

Sales and Use and Personal Property Tax Audits

Our hospitals are routinely subject to sales and use tax audits and personal property tax audits by the state and local government jurisdictions in which they do business. The results of the audits are frequently disputed, and such disputes are ordinarily resolved by administrative appeals or litigation.

MISCELLANEOUS CIVIL LAWSUITS

***United States ex. rel. Dr. Man Tai Lam and Dr. William Meschel v. Tenet Healthcare Corporation*, Case No. EP-02-CA-0525KC (U.S. District Court for the Western District of Texas)**

On December 28, 2005, we were served with a summons and third amended complaint in this qui tam action, which had originally been filed by the relators on November 8, 2002 and which remained under seal until the DOJ decided to not intervene in the matter and the court lifted the seal on July 18, 2005. The complaint alleged violations of the federal False Claims Act by Tenet hospitals in El Paso, Texas arising out of:

(1) alleged violations of the federal anti-kickback statute in

connection with certain financial arrangements with physicians; and (2) the alleged manipulation of the hospitals charges in order to increase outlier payments. We served our response to the complaint on February 27, 2006 and moved to dismiss the case. On April 27, 2006, the DOJ filed a statement of interest joining our motion to dismiss on the basis that the court lacks jurisdiction over the case because the relators are not original sources of the alleged violations of the False Claims Act. On August 15, 2006, the court granted our motion to dismiss the kickback claims, but denied the motion with respect to the outlier claim.

On September 14, 2006, we were served with a fourth amended complaint in this matter. The relators continue to allege violations of the federal anti-kickback statute and manipulation of hospital charges in order to increase outlier payments. We served our response to the complaint on October 2, 2006 and have again moved to dismiss the case. Our motion is still pending. On November 9, 2006, the government sought to intervene in the case for the purpose of moving to dismiss the relators outlier claim on the basis that the claim was not plead with sufficient particularity. The district court has not yet ruled on the government s motion to dismiss.

***United States ex rel. Bruce G. Lowman v. Hilton Head Medical Center and Clinics, et al.*, Case No. 9:05-2533-PMD (U.S. District Court for the District of South Carolina)**

On July 20, 2006, the DOJ filed a notice to unseal and declining to intervene in a qui tam lawsuit, which was filed under seal on September 1, 2005, against the Company, our Hilton Head Medical Center and Clinics in South Carolina and related subsidiaries, as well as a cardiologist who was not our employee, but formerly practiced at Hilton Head. The unsealing order was signed by the judge on July 25, 2006. The relator, a physician no longer on Hilton Head s medical staff, alleges under the federal False Claims Act that we received inappropriate payments from Medicare for certain cardiac catheterization procedures that were performed by the cardiologist from 1997 through 2003, during which time Hilton Head did not have a state certificate of need for open heart surgery capability, which was required under South Carolina regulations for facilities performing those procedures. The suit also alleges that certain of the catheterization procedures were medically unnecessary, although it provides no specific information regarding these claims. We were formally served with the complaint on November 20, 2006; subsequently, we filed a motion to dismiss this matter, which remains pending. Despite the government s decision not to intervene in this case, the relator intends to continue to litigate the matter independently.

We had previously self-disclosed to the South Carolina Department of Health and Environmental Control (DHEC) in 2001 that 436 therapeutic cardiac catheterization procedures had been performed at Hilton Head between January 1, 1997 and March 31, 2000 when that facility lacked a certificate of need for open heart surgery, and that, of these, 242 were deemed non-emergent and 194 were deemed emergent. DHEC and Hilton Head entered into a Consent Order on February 2, 2001 whereby DHEC found that there was no intentional violation of state laws or regulations and whereby Hilton Head paid a civil penalty of $100 per non-emergent procedure, or $24,200. Subsequently, in July 2002, Hilton Head received its certificate of need for open heart surgery, and it has been performing therapeutic cardiac catheterizations since that time.

***Boca Raton Community Hospital, Inc. v. Tenet Healthcare Corporation*, Case No. 05-80183-CIV (U.S. District Court for the Southern District of Florida, filed March 2, 2005)**

Plaintiff filed a civil complaint in federal district court in Miami on March 2, 2005 on behalf of itself and a purported class consisting of most of the acute care hospitals in the United States. Although several of plaintiff s initial claims have since been withdrawn or dismissed, plaintiff is proceeding with the allegation that Tenet s past pricing policies and receipt of Medicare outlier payments violated the federal Racketeer Influenced and Corrupt Organizations Act (RICO), causing harm to plaintiff. Plaintiff seeks unspecified amounts of damages (including treble damages under RICO), restitution, disgorgement and punitive damages. In December 2006, the district court denied plaintiff s motion for class certification. Plaintiff subsequently petitioned the U.S. Court of Appeals for the Eleventh Circuit seeking permission to file an interlocutory appeal of the district court s denial of class certification. We filed an opposition to that petition on January 8, 2007. On February 13, 2007, the Eleventh Circuit denied plaintiff s petition for leave to appeal the district court s decision. We have filed a motion for summary judgment on all claims, which is pending before the district court.

***Brockovich, on behalf of the United States of America v. Tenet Healthcare Corporation, et al.*,**

Case No. CV 06-4542 DOC (MLGx) (U.S. District Court for the Central District of California)

Plaintiff Erin Brockovich, purportedly on behalf of the United States of America, filed a civil complaint in Los Angeles Superior Court on June 2, 2006, alleging that Tenet and several of our subsidiaries inappropriately received reimbursement from Medicare for treatment given to patients whose injuries were caused by the Company and those

subsidiaries as a result of medical error or neglect. This matter is one of approximately 30 identical lawsuits that plaintiff Brockovich has filed against most of the major hospital systems and nursing homes in California. In addition, her attorneys have filed similar cases in New Jersey and Florida using others as plaintiffs. In this case, plaintiff is seeking damages of twice the amount that defendants were allegedly obligated to pay or reimburse Medicare in connection with the treatment in question, plus interest, together with plaintiff s costs and fees, including attorneys fees. In July 2006, defendants removed the case to federal court and, in August 2006, filed a motion to dismiss the matter. On November 15, 2006, defendants motion to dismiss was granted on the basis that plaintiff Brockovich lacks constitutional standing. On December 4, 2006, plaintiff filed a notice of her intention to appeal the dismissal. We believe that the trial court s order was correct and intend to vigorously defend that order on appeal.

***University of Southern California v. USC University Hospital, Inc., et al.*, Case No. BC357352 (Los Angeles Superior Court, filed August 22, 2006)**

On August 22, 2006, plaintiff University of Southern California filed a lawsuit in Los Angeles Superior Court against a Tenet subsidiary seeking to terminate a ground lease and a development and operating agreement between the University and the subsidiary, which built, owns and operates USC University Hospital, an acute care hospital located on land leased from the University in Los Angeles. Plaintiff s complaint alleges that the lease and operating agreement should be terminated as a result of a default by us and seeks a judicial declaration terminating the agreements in an effort to force us to sell the hospital to the University. We strongly dispute the University s claims and are seeking to compel arbitration of the dispute as is mandated by the development and operating agreement. By order dated December 18, 2006, the trial court denied our motion to compel arbitration; however, on January 2, 2007, we filed an appeal of that decision, and the case has been stayed pending the appeal.

MANAGED CARE INSURANCE DISPUTES

We and our subsidiaries are from time to time engaged in disputes with managed care payers. For the most part, we believe the issues raised in these contract interpretation and rate disputes are commonly encountered by other providers in the health care industry.

MEDICAL MALPRACTICE AND OTHER ORDINARY COURSE MATTERS

In addition to the matters described above, our hospitals are subject to claims and lawsuits in the ordinary course of business. The largest category of these relates to medical malpractice. Three of these medical malpractice cases were filed as purported class action lawsuits and involve former patients of Memorial Medical Center and Lindy Boggs Medical Center in New Orleans. In each case, family members allege, on behalf of themselves and a purported class of other patients and their family members, damages as a result of injuries sustained during Hurricane Katrina. In addition to disputing the merits of the allegations in these suits, we contend that certification of a class in these actions is not appropriate and that each of these cases must be adjudicated independently. We will, therefore, oppose class certification and vigorously defend the hospitals in these matters.

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

None.

PART II.

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

Common Stock. Our common stock is listed on the New York Stock Exchange under the symbol THC. On June 2, 2006, we submitted an annual CEO certification to the NYSE regarding our compliance with the NYSE s corporate governance listing standards. The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock on the NYSE.

	High	Low
Year Ended December 31, 2006		
First Quarter	$ 8.25	$ 6.89
Second Quarter	9.27	6.77
Third Quarter	8.69	5.77
Fourth Quarter	8.49	6.73
Year Ended December 31, 2005		
First Quarter	$ 12.20	$ 9.77
Second Quarter	12.93	11.35
Third Quarter	13.06	10.95
Fourth Quarter	11.49	7.27

On February 16, 2007, the last reported sales price of our common stock on the NYSE composite tape was $7.32 per share. As of that date, there were approximately 8,892 holders of record of our common stock. Our transfer agent and registrar is The Bank of New York. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (800) 524-4458.

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

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

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to three indices, each of which includes us. The Standard & Poor s 500 Stock Index includes 500 companies representing all major industries. The Standard & Poor s Healthcare Composite Index is a group of 55 companies involved in a variety of health care related businesses. Because the Standard & Poor s Healthcare Composite Index is heavily weighted by pharmaceutical companies, we believe that at times it may be less useful than the Hospital Management Peer Group Index included below. We compiled this Peer Group Index by selecting publicly traded companies that have as their primary business the management of acute care hospitals and that have been in business for all five of the years shown. These companies are: Health Management Associates, Inc. (HMA), Tenet Healthcare Corporation (THC), Triad Hospitals, Inc. (TRI) and Universal Health Services, Inc. (UHS). Not included is HCA, Inc., which was a member of our Peer Group Index in prior years, because HCA became a privately held company in November 2006.

Performance data assumes that $100.00 was invested on December 31, 2001 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Stock price performance shown in the graph is not necessarily indicative of future stock price performance.

	12/01	12/02	12/03	12/04	12/05	12/06
Tenet Healthcare Corporation	$ 100.00	$ 41.89	$ 41.00	$ 28.05	$ 19.57	$ 17.80
S & P 500	$ 100.00	$ 77.90	$ 100.24	$ 111.15	$ 116.61	$ 135.03
S & P Health Care	$ 100.00	$ 81.17	$ 93.40	$ 94.96	$ 101.10	$ 108.71
Peer Group	$ 100.00	$ 60.56	$ 67.85	$ 57.59	$ 52.54	$ 53.29

ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

In March 2003, our board of directors approved a change in our fiscal year from a fiscal year ending on May 31 to a fiscal year that coincides with the calendar year, effective December 31, 2002. The following tables present selected audited consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2006, 2005, 2004 and 2003, the seven-month transition period ended December 31, 2002, and the fiscal year ended May 31, 2002.

	Years ended December 31,				Seven months ended December 31,	Year ended May 31,
	2006	2005	2004	2003	2002	2002
	(In Millions, Except Per-Share Amounts)					
Net operating revenues	**$ 8,701**	**$ 8,614**	**$ 8,768**	**$ 8,837**	**$ 5,330**	**$ 8,629**
Operating expenses:						
Salaries, wages and benefits	3,883	3,922	3,843	3,767	2,088	3,433
Supplies	1,587	1,574	1,502	1,390	760	1,200
Provision for doubtful accounts	530	625	1,073	996	421	625
Other operating expenses	2,014	1,921	1,924	1,837	1,022	1,677
Depreciation	313	306	317	311	179	300
Goodwill amortization						83
Other amortization	29	26	17	18	12	21
Impairment of long-lived assets and goodwill, net of insurance recoveries	376	36	1,207	1,232	4	76
Restructuring charges	4	10	48	105	5	25
Hurricane insurance recoveries, net of costs	(14)	13				
Costs of litigation and investigations	766	212	74	282		
Loss from early extinguishment of debt		15	13		4	383
Operating income (loss)	**(787)**	**(46)**	**(1,250)**	**(1,101)**	**835**	**806**
Interest expense	(409)	(404)	(332)	(293)	(143)	(323)
Investment earnings	62	59	20	16	13	30
Minority interests	(4)	(3)	(4)	(11)	(5)	(19)
Net gains on sales of facilities, long-term investments and subsidiary common stock	5	4	7	16		
Impairment of investment securities				(5)	(64)	
Income (loss) before income taxes	**(1,133)**	**(390)**	**(1,559)**	**(1,378)**	**636**	**494**
Income tax (expense) benefit	262	84	(295)	272	(254)	(252)
Income (loss) from continuing operations, before discontinued operations and cumulative effect of changes in accounting principle	**$ (871)**	**$ (306)**	**$ (1,854)**	**$ (1,106)**	**$ 382**	**$ 242**
Basic earnings (loss) per common share from continuing operations(1)	**$ (1.85)**	**$ (0.65)**	**$ (3.98)**	**$ (2.37)**	**$ 0.79**	**$ 0.49**
Diluted earnings (loss) per common share from continuing operations(1)	**$ (1.85)**	**$ (0.65)**	**$ (3.98)**	**$ (2.37)**	**$ 0.77**	**$ 0.48**

(1) All periods have been adjusted to reflect a 3-for-2 stock split declared in May 2002 and distributed on June 28, 2002.

The operating results data presented above are not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly trends in patient accounts receivable collectibility and associated provisions for doubtful accounts; the timing and magnitude of price changes; fluctuations in contractual allowances, including the impact of the discounting components of our *Compact with Uninsured Patients* (Compact) and cost report settlements and valuation allowances; managed care contract negotiations or terminations and payer consolidations; changes in Medicare regulations; Medicaid funding levels set by the states in which we operate; levels of malpractice expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and valuation allowances; the timing and amounts of stock option and restricted stock unit grants to employees, directors and others; and changes in occupancy levels and patient volumes. Factors that affect our patient volumes and, thereby, our results of operations at our hospitals and related health care facilities include, but are not limited to: the business environment of local communities; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment,

retention and attrition; advances in technology and treatments that reduce length of stay; local health care competitors; managed care contract negotiations or terminations; unfavorable publicity about us, which impacts our relationships with physicians and patients; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

BALANCE SHEET DATA

	December 31,					May 31,
	2006	2005	2004	2003	2002	2002
	(In Millions)					
Working capital (current assets minus current liabilities)	$ 1,100	$ 1,216	$ 1,882	$ 1,908	$ 1,542	$ 962
Total assets	8,539	9,812	10,081	12,298	13,895	13,957
Long-term debt, net of current portion	4,760	4,784	4,395	4,039	3,872	3,919
Shareholders equity	264	1,021	1,699	4,374	5,924	5,802

CASH FLOW DATA

	Years ended December 31,				Seven months ended December 31,	Year ended May 31,
	2006	2005	2004	2003	2002	2002
	(In Millions)					
Net cash provided by (used in) operating activities	$ (462)	$ 763	$ (82)	$ 838	$ 1,126	$ 2,315
Net cash used in investing activities	(379)	(392)	(12)	(333)	(389)	(1,227)
Net cash provided by (used in) financing activities	252	348	129	(96)	(565)	(1,112)

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

INTRODUCTION TO MANAGEMENT S DISCUSSION AND ANALYSIS

The purpose of this section, Management s Discussion and Analysis of Financial Condition and Results of Operations, is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which financial information may be analyzed, and to provide information about the quality of, and potential variability of, our results of operations and cash flows. Unless otherwise indicated, all financial and statistical information included herein relates to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). This information should be read in conjunction with the accompanying Consolidated Financial Statements. It includes the following sections:

- Executive Overview
- Sources of Revenue
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Recently Issued Accounting Standards

- Critical Accounting Estimates

EXECUTIVE OVERVIEW

KEY DEVELOPMENTS

During 2006, we continued to focus on the execution of our turnaround strategies. While we saw certain areas of improvement this year, we are still facing several industry and company-specific challenges that continue to negatively affect our progress. We are dedicated to improving our patients , shareholders and other stakeholders confidence in us. We still believe we will do that by providing quality care and generating positive growth and earnings at our hospitals.

Key developments include the following events:

- *New Independent Auditor* In January 2007, we announced that Deloitte & Touche LLP had been selected by our audit committee as our new independent registered public accounting firm for the year ending December 31, 2007. The engagement of Deloitte & Touche will be submitted for ratification by our shareholders at our May 2007 annual meeting.

- *New Inpatient Tower at USC University Hospital* In January 2007, we announced the opening of the Norris Inpatient Tower, a state-of-the-art, $150 million, ten-story building connected to our USC University Hospital. The Norris Inpatient Tower will have 146 beds, which significantly expands the hospital s capacity for treating patients with cancer and other life-threatening illnesses and supporting advanced medical research.

- *New Ten-Year IT Outsourcing Agreement* In November 2006, we signed a new contract with Perot Systems Corporation that expands, extends and strengthens the information technology support and management services that Perot Systems has provided for us and our hospitals since 1990. We expect the agreement will enhance our information systems to provide a strong foundation for the introduction of advanced medical information technology designed to further improve quality of care and patient safety at all of our hospitals. The new contract also restructures our previous agreement to better fit our smaller size after recent divestitures. In addition, the agreement provides for the global outsourcing of certain information technology support functions. Aggregate fees under the agreement are expected to be approximately $1.1 billion over the ten-year term of the contract.

- *IRS Audit and Settlement* In October 2006, we received a Revenue Agent s Report related to the recently completed Internal Revenue Service (IRS) audit of our tax returns for fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002. The report assessed an aggregate tax deficiency of $207 million plus interest ($54 million as of December 31, 2006). Of the $207 million proposed assessment, approximately $125 million is attributable to issues that are not in dispute. After taking into account net operating losses from 2004, which offset a portion of the undisputed tax deficiency, the remaining undisputed amount is reduced to approximately $85 million. We paid this undisputed tax deficiency of $85 million, plus interest thereon of $25 million, in December 2006. In November 2006, we also reached a partial settlement with the IRS related to issues that were in dispute for fiscal years 1995, 1996 and 1997 and paid $80 million as an advance payment of taxes and interest owed under the settlement, with respect to those matters.

- *New Revolving Credit Facility* In September 2006, we accepted a commitment from a group of banks for a five-year, $800 million senior secured revolving credit facility, which we closed in November 2006, thereby replacing our $250 million letter of credit facility. The revolving credit facility is collateralized by patient accounts receivable, and can be increased to $1 billion depending on the amount of eligible receivables outstanding. Existing letters of credit were transferred into the revolving credit facility, which reduced the amount available for cash borrowings, but eliminated the restriction on $263 million of cash pledged under our prior letter of credit agreement. The new credit facility is subject to customary covenants for an asset-backed facility. The covenants include a minimum fixed charge coverage ratio to be met when the available credit under the facility falls below $100 million, as well as limits on debt, liens, asset sales and prepayments of senior debt. Standard & Poor s lowered its credit rating on our senior unsecured notes two notches to CCC+ due to the large amount of priority debt that now exists, but changed its outlook on our corporate credit rating from negative to stable, reflecting our recently improved managed care pricing, better expense management, asset divestiture plan and the elimination of key litigation risks. Moody s lowered its credit rating on our unsecured notes one notch to Caa1, but also affirmed the corporate family rating of B3. In addition, Moody s changed the rating outlook on the corporate family rating from negative to stable.

- *Expiration of Operating Leases* In August 2006, Metrocrest Hospital Authority announced that another company was selected to manage RHD Memorial Medical Center in Farmers Branch, Texas and Trinity Medical

Center in Carrollton, Texas following the expiration of our operating lease. The results of these hospitals will be included in continuing operations until the lease expires in August 2007. For the years ended December 31, 2006 and 2005, the combined operating loss of these two hospitals was $23 million and $15 million, respectively. As of December 31, 2006, our investment in the collateralized bonds issued by the local hospital authority was $95 million. Of this amount, $31 million matures in 2007 and $64 million matures in 2010.

- *Settlement Reached over Katrina Insurance Claims* In July 2006, we announced a $340 million settlement had been reached with our property insurers regarding claims related to the physical damage and business interruption we sustained as a result of Hurricane Katrina in 2005. We received $240 million in July 2006, in addition to the $100 million previously received, in full resolution of our claims. With the settlement, we have avoided a protracted resolution process fraught with the disagreements and differences over interpretation that can occur in insurance claims of this magnitude and complexity. As provided in our insurance contracts, we have the flexibility to apply these funds to meet our overall capital needs.

- *Global Civil Settlement and Corporate Integrity Agreement* In June 2006, we entered into a broad civil settlement agreement with the U.S. Department of Justice and other federal agencies that concluded several previously disclosed governmental investigations, including inquiries into our receipt of certain Medicare outlier payments before 2003, physician financial arrangements and Medicare coding issues. Under the terms of the settlement, we will pay $725 million, plus interest, over a four-year period and waive our right to pursue receipt of $175 million in unrecorded Medicare payments for past services. With this global settlement and the previously announced settlements of the criminal case involving Alvarado Hospital Medical Center, civil pricing litigation, a securities lawsuit and shareholder derivative litigation, and several issues with the Florida Attorney General, as well as certain other legal matters, we have now resolved the majority of lawsuits and investigations related to legacy issues that had been ongoing for the past several years.

As part of the global settlement, we entered into a five-year corporate integrity agreement with the Office of Inspector General of the U.S. Department of Health and Human Services in September 2006. The agreement requires us to maintain our quality initiatives, compliance program and code of conduct, as well as formalize in writing our policies and procedures in the areas of billing and reimbursement, federal anti-kickback and Stark laws, and clinical quality. It also establishes general and specialized training requirements and compliance reviews by independent organizations in the areas of Medicare outlier payments, diagnosis-related group claims, unallowable costs, physician financial arrangements and clinical quality systems. Because of the many changes and enhancements we have made in the past three years, we already had in place a number of the procedures and systems called for by the agreement; therefore, we do not anticipate compliance with this agreement to create a significant burden on us or have a material effect on our results of operations or cash flows.

- *Strategic Divestitures* In June 2006, we announced our strategic plan to divest 10 general hospitals, primarily to enhance our future profitability, provide funds to expand capital investments at our remaining hospitals and help fund our global civil settlement with the federal government. In addition to Gulf Coast Medical Center in Biloxi, Mississippi, which we sold in June 2006 for estimated net after-tax proceeds of $14 million, Alvarado Hospital Medical Center, which we agreed to divest as part of our May 2006 settlement with the U.S. Attorney in San Diego and sold in January 2007 for estimated pretax proceeds of $22 million, and other hospitals currently held for sale or already sold, these 10 hospitals are reported in discontinued operations for all periods presented in this report. The 10 hospitals included: four in the New Orleans area Kenner Regional Medical Center, Lindy Boggs Medical Center, Meadowcrest Hospital and Memorial Medical Center because of uncertainties in the New Orleans market and the need for health care consolidation there in the aftermath of Hurricane Katrina; three of our five hospitals in Philadelphia Graduate Hospital, Roxborough Memorial Hospital and Warminster Hospital; and three of our Florida hospitals Hollywood Medical Center, Parkway Regional Medical Center and Cleveland Clinic Hospital.

In September 2006, we completed the sale of Kenner Regional Medical Center, Meadowcrest Hospital and Memorial Medical Center. Pretax proceeds are estimated to be approximately $48 million. In addition, the buyer has agreed to reimburse us approximately $8 million for our costs related to the reconstruction of the New Orleans Surgical and Heart Institute on the campus of Memorial Medical Center. Also in September 2006, we completed the sale of our 51% partnership interest in Cleveland Clinic Hospital for pretax proceeds, including the repayment of partnership loans from us, of approximately $90 million. In November 2006, we completed the sale of Hollywood Medical Center for pretax proceeds of approximately $32 million and, in December 2006, we sold Parkway Regional Medical Center for estimated pretax proceeds of approximately $35 million. Discussions and negotiations with potential buyers for the remaining hospitals slated for divestiture are ongoing.

- *Strategic Development of Outpatient Services* In May 2006, we announced that we had formed a national strategic development group to focus on our freestanding and hospital-based outpatient services and facilities. We

currently operate more than 40 imaging and diagnostic centers, more than 20 ambulatory surgery centers and a

31

number of other outpatient facilities. In addition, we have 25 outpatient projects currently in development, most of them on the campuses of our hospitals. The strategic group s goal is to ensure that each of our hospitals and markets is actively pursuing multiple outpatient growth opportunities.

SIGNIFICANT CHALLENGES

Our June 2006 global civil settlement with the federal government and other previously announced settlements have resolved several material threats to our company and should help us move forward in our turnaround strategy. However, there are still significant challenges, both company-specific and industry-wide, that will impact the timing of our turnaround. Below is a summary of these items.

Company-Specific Challenge

Volumes We believe the reasons for declines in our volumes include, but are not limited to, decreases in the demand for invasive cardiac procedures, increased competition, physician attrition, managed care contract negotiations or terminations, a declining population in Florida, and the impact of our litigation and government investigations. We are taking a number of steps in addition to the settlement of litigation and government investigations to address the problem of volume decline; however, due to the concentration of our hospitals in California, Florida and Texas, we may not be able to mitigate some factors contributing to volume declines. One of these initiatives is our *Physician Sales and Service Program*, which is centered around understanding the needs of physicians who admit patients both to our hospitals and to our competitors hospitals and responding to those needs with changes and improvements in our hospitals and operations. We accelerated capital spending for 2006 in order to address specific needs of our hospitals, which is expected to have a positive impact on their volumes. We are also completing clinical service line market demand analysis and profitability assessments to determine which services are highly valued that can be emphasized and marketed to improve results. This *Targeted Growth Initiative* has resulted in some reductions in unprofitable service lines in several locations, which have had a slightly negative impact on our volumes. However, the elimination of these unprofitable service lines will allow us to focus more resources on services that are highly valued and more profitable.

Our *Commitment to Quality* initiative, which we launched in 2003, should further help position us to competitively meet the volume challenge. We are working with physicians to implement the most current evidence-based techniques to improve the way we provide care. Our hospitals have improved substantially in quality metrics reported by the government and have been recognized by several managed care companies for their quality of care. We have seen an increase in admissions for certain service lines at our facilities that have been designated as *Centers of Excellence* by managed care companies due to their record of quality clinical outcomes. Although *Centers of Excellence* designations are limited, certain managed care companies are offering attractive financial incentives to their members to encourage the use of *Centers of Excellence* designated service lines that have consistently achieved improved clinical outcomes. We believe that quality of care improvements will continue to have the effect of increasing physician and patient satisfaction, potentially improving our volumes as a result.

Significant Industry Trends

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

Cost Pressures Labor and supply costs remain a significant cost pressure facing us as well as the industry in general. We have slowed the rates of increase in both labor and supply costs and have been able to contain our unit cost growth below the rate of medical inflation. Maintaining this level of cost control in an environment of declining patient

volumes and increasing labor union activity will continue to be a challenge.

RESULTS OF OPERATIONS OVERVIEW

Our results of operations for the last three years reflect the progress we have made in restructuring our operations to focus on a smaller group of general hospitals. Our turnaround timeframe has been and continues to be influenced by industry trends such as bad debt levels and by company-specific challenges, such as decreasing volumes and demand for inpatient cardiac procedures, that continue to negatively affect our revenue growth and operating expenses. Our future profitability depends on volume growth, adequate reimbursement levels and cost control.

Results of operations Year ended December 31, 2006 compared to the year ended December 31, 2005:

- Net inpatient revenue per patient day and per admission increased by 6.9% and 4.6%, respectively, due primarily to the effect of newly negotiated levels of reimbursement from our managed care contracts, partially offset by additional discounts under the Compact during the phase-in process. Patient days were down 4.5% and admissions were down 2.5%.

- Net outpatient revenue per visit increased 5.1%, while outpatient visits declined 5.2%. The increase in revenue per visit is due primarily to higher Medicare and Medicaid reimbursement and the effect of newly negotiated levels of reimbursement from our managed care contracts, partially offset by additional discounts under the Compact during the phase-in process.

- Loss per diluted share from continuing operations of $1.85 in the current year increased from the loss per diluted share of $0.65 in the prior year due primarily to the current year s litigation settlements and impairments.

Results of operations Year ended December 31, 2005 compared to the year ended December 31, 2004:

- Net inpatient revenue per patient day and per admission increased by 2.2% and 1.5%, respectively, due primarily to the effect of newly negotiated levels of reimbursement from our managed care contracts and slightly higher Medicare reimbursement levels, offset by additional discounts under the Compact during the phase-in process.

- Net outpatient revenue per visit increased 2.4%, while outpatient visits declined 7.8%. The increase in revenue per visit is due primarily to higher emergency room volume, a positive shift in payer mix and the sale or closure of certain home health agencies, hospices and clinics, which businesses typically generate lower revenue per visit amounts than other outpatient services, partially offset by additional discounts under the Compact during the phase-in process and lower rehabilitation visits.

- Favorable net adjustments for prior-year cost reports and related valuation allowances, related primarily to Medicare and Medicaid, of $44 million in 2005 increased compared to similar favorable adjustments of $3 million in 2004.

- Cash generated by operating activities was $763 million during 2005 compared to cash used by operations of $82 million during 2004, reflecting an income tax refund of $537 million received in March 2005 and lower restructuring and litigation settlement payments.

- Loss per diluted share from continuing operations of $0.65 in 2005 decreased from the loss per diluted share of $3.98 in 2004 due primarily to lower impairments.

The table below shows the pretax and after-tax impact on continuing operations for each of the three years ended December 31, 2006, 2005 and 2004 of the following items:

	Years ended December 31,		
	2006	2005	2004
	(Expense) Income		
Change in estimate of provision for doubtful accounts	$	$	$ (170)
Change in prior-year liability estimates for retirement plans	14	31	
Impairment of long-lived assets and goodwill	(376)	(36)	(1,207)
Restructuring charges	(4)	(10)	(48)
Hurricane insurance recoveries, net of costs	14	(13)	
Costs of litigation and investigations	(766)	(212)	(74)
Net gains on sales of facilities, long-term investments and subsidiary common stock	5	4	7
Loss from early extinguishment of debt		(15)	(13)
Pretax impact	$ (1,113)	$ (251)	$ (1,505)
Reduction in estimated tax exposures, including interest	$ 42	$ 24	$
Deferred tax asset valuation allowance	$ (140)	$ (101)	$ (569)
Total after-tax impact	$ (857)	$ (237)	$ (1,799)
Diluted per-share impact of above items	$ (1.82)	$ (0.50)	$ (3.86)
Diluted loss per share, including above items	$ (1.85)	$ (0.65)	$ (3.98)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Net cash used in operating activities was $462 million in 2006 compared to net cash provided by operating activities of $763 million in 2005. The principal reasons for the change were:

- an additional $599 million in payments during the current year compared to the prior year for legal settlements and related costs comprised primarily of the June 2006 global civil settlement payment to the federal government ($470 million), the payments in March 2006 in connection with the settlement of a securities class action lawsuit and state shareholder derivative litigation ($145 million) and our February 2006 settlement with the Florida Attorney General ($7 million);

- an income tax refund of $537 million received in March 2005 compared to $215 million in income tax payments in 2006, primarily for the settlement of prior year audits;

- an additional $44 million of 401(k) matching contributions due to a full year of contribution matching in the current year compared to six months of contribution matching in the prior year (effective July 1, 2004, we changed to an annual matching of employee 401(k) plan contributions for participants actively employed on December 31, as opposed to matching such contributions each pay period);

- an additional $19 million of interest expense payments in 2006 due to debt issuances in January 2005; and

- hurricane insurance recoveries of $161 million in 2006.

Proceeds from the sales of facilities, long-term investments and other assets during 2006 and 2005 aggregated $244 million and $173 million, respectively.

In November 2006, we entered into a five-year, $800 million senior secured revolving credit facility, that replaced our $250 million letter of credit facility. The revolving credit facility is collateralized by patient accounts receivable at our acute care and specialty hospitals, and bears interest at our option based on the London Interbank Offered Rate plus 175 basis points or Citigroup s base rate, as defined in the credit

agreement, plus 75 basis points. After six months from the start of the credit agreement, the interest spread over the London Interbank Offered Rate and Citigroup s base rate may be reduced by 25 basis points if our leverage ratio, as defined in the credit agreement, is below the defined threshold. The letters of credit outstanding under our previous letter of credit facility were transferred into the revolving credit facility, which reduced the amount

available for cash borrowings, but eliminated the restriction on $263 million of cash pledged under the letter of credit agreement. At December 31, 2006, there were no borrowings under the revolving credit facility.

In January 2005, we sold $800 million of 9¼% senior notes due in 2015. The net proceeds from the sale of the senior notes were approximately $773 million after deducting discounts and related expenses. We used a portion of the proceeds in February 2005 for the early redemption of the remaining $400 million aggregate principal amount outstanding on our senior notes due in 2006 and 2007, and the balance of the proceeds for general corporate purposes.

In June 2004, we sold $1 billion of 97/8% senior notes due in 2014. The net proceeds from the sale of the senior notes were approximately $954 million after deducting discounts and related expenses. We used a portion of the proceeds to repurchase $335 million of our senior notes due in 2006, $215 million of our senior notes due in 2007 and $2 million of our senior notes due in 2008.

We are currently in compliance with all covenants and conditions in our revolving credit agreement and the indentures governing our senior notes. (See Note 6 to the Consolidated Financial Statements.)

At December 31, 2006, we had approximately $190 million of letters of credit outstanding under our revolving credit facility. In addition, we had approximately $784 million of unrestricted cash and cash equivalents on hand and borrowing capacity of $596 million under our revolving credit facility as of December 31, 2006.

SOURCES OF REVENUE

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

The table below shows the sources of net patient revenues for our general hospitals, expressed as percentages of net patient revenues from all sources:

	Years ended December 31,					
Net Patient Revenues from:	**2006**		**2005**		**2004**	
Medicare	26.5	%	27.4	%	25.7	%
Medicaid	9.0	%	8.4	%	7.5	%
Managed care(1)	52.3	%	50.7	%	49.8	%
Indemnity, self-pay and other	12.2	%	13.5	%	17.0	%

(1) Includes Medicare Advantage and Medicaid managed care.

The decrease in indemnity, self-pay and other net patient revenues since 2004 is due primarily to the implementation of the discounting components of the Compact. Our payer mix on an admissions basis for our general hospitals, expressed as a percentage of total admissions from all sources, is shown below:

	Years ended December 31,					
Admissions from:	**2006**		**2005**		**2004**	
Medicare	32.2	%	33.5	%	33.7	%
Medicaid	13.1	%	13.6	%	13.2	%
Managed care(1)	45.9	%	44.6	%	44.8	%
Indemnity, self-pay and other	8.8	%	8.3	%	8.3	%

(1) Includes Medicare Advantage and Medicaid managed care.

The increase in managed care admissions since 2005 is due primarily to an overall shift in our patient mix from Medicare and Medicaid to managed Medicare and Medicaid as further discussed below.

GOVERNMENT PROGRAMS

The Medicare program, the nation s largest health insurance program, is administered by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services. Medicare is a health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is a program that pays for medical and health-related services for certain individuals and families with low incomes and resources, and is jointly funded by the federal government and state governments. Medicaid is the largest source of funding for medical and health-related services for the nation s poorest and most vulnerable populations.

These government programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are unable to predict the effect of future government health care funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited or if we, or one or more of our subsidiaries hospitals, are excluded from participation in the Medicare or Medicaid program or any other government health care program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

Medicare

Medicare offers beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan, is a fee-for-service payment system. The other option, called Medicare Advantage (formerly Medicare + Choice), includes managed care, preferred provider organization, private fee-for-service and specialty plans. The major components of our net patient revenues for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2006, 2005 and 2004 are set forth in the table below:

	Years ended December 31,		
Revenue Descriptions	**2006**	**2005**	**2004**
Diagnosis-related group operating	$ 1,264	$ 1,290	$ 1,240
Diagnosis-related group capital	127	133	131
Outlier	78	74	58
Outpatient	368	361	367
Disproportionate share			